



Association News

Stanley J. Matek Assumes APHA Presidency

Stanley J. Matek, MS, Executive Director of the Orange County Health Planning Council in Tustin, California, a position he has held since 1973, assumed the presidency of the American Public Health Association on November 5, 1981, at the close of the Association's Annual Meeting in Los Angeles. Matek, chosen as APHA President-Elect at last year's meeting in Detroit, has served in that capacity for one year; his term as President is also for one year, through the time of the APHA 110th Annual Meeting in Montreal, November 14-18, 1982.

A member of APHA since 1969, Matek has been an articulate spokesperson for public health throughout his professional career, and an active member of the Association. Affiliated with the Community Health Planning Section, he has served on the CHP Section Council (1971-74) and was a member of the Nominating Committee (1975); twice a member of the Governing Council (1971-74 and 1976-81); served on the Program Committee for the Association's Centennial (1972); and has been a member of the Executive Board since 1976. His tenure on the Executive Board will continue through 1983 when he will officially serve as Immediate Past President of APHA.

Matek attended Kilroe College, received his bachelor's degree in philosophy from Catholic University of America in 1963, and then received his master's degree in community

planning from the University of Wisconsin, Milwaukee in 1968. At that time, he was named Associate Director of the Milwaukee County Mental Health Planning Council for one year, and then served as its Executive Director until 1973. From 1971-1973, he was a member of the Wisconsin Governor's Task Force on Health Planning and Policy, and chairman of the Health Planning Section. Subsequently, he was a member of the National Task Force on the Future of Nursing, Office of the Surgeon General, Division of Nursing (1975-76).

His professional interests include health planning and policy development, political science, management, systems relationships, public speaking, and future studies. Since 1976, he has been a member of the California Medical Quality Review Board, Area 13. His past academic appointments include field instructor, University of Wisconsin Graduate School of Social Welfare (1970-73), and lecturer in social ecology for the Graduate Division of the University of California at Irvine (1974-75).

He holds professional memberships in the American Association of Hospital Managers, the American Society for Public Administration, the Future Society, and the American Health Planning Association, where he has served on the Board of Directors and the Government Policy Committee.

Anthony Robbins, MD, MPA, Chosen President-Elect

Anthony Robbins, MD, MPA, a professional staff member for the Committee on Energy and Commerce, US House of Representatives, was chosen as the President-Elect of APHA by the Governing Council on November 4, 1981.

From 1978 to early 1981, Robbins was Director of the National Institute for Occupational Safety and Health, the federal agency that does research on workplace hazards and provides technical support to related agencies. Prior to that he was Executive Director of the Colorado Department of Health and Associate Clinical Professor, University of Colorado Medical Center. He has also held the positions of State Health Commissioner of Vermont, and Director of Profes-

sional Relations and Community Health Development, National New England Regional Medical Program. Other faculty appointments have included the University of Vermont, Dartmouth College, and McGill University.

Dr. Robbins completed his undergraduate work at Harvard College, received his medical degree from Yale University School of Medicine, and earned his graduate degree in public administration from Harvard University.

Within APHA, he has been affiliated with both the Medical Care and the Occupational Health and Safety Sections, and is a past chairperson of the Association's Action Board. His other professional memberships include the

Colorado Public Health Association, Canadian Public Health Association, Medical Committee for Human Rights, and Physicians for Social Responsibility. He has been an

associate editor of the *American Journal of Industrial Medicine* and an editorial consultant to the *Journal of Public Health Policy*.

Executive Board and Other Elections

The Governing Council also elected three new members to the Executive Board, each to serve four-year terms. The new members are:

● **Dorothy P. Rice**, BA, DSc (Honorary), is Director, National Center for Health Statistics, who has been a federal career civil servant for 29 years, serving in various administrative, statistical, and research positions in the Department of Health and Human Services and its predecessor agencies. A fellow of APHA, she received the APHA Domestic Award for Excellence in 1978, has served on the Governing Council and on the Health Services Research Committee of the Medical Care Section, as well as the Editorial Board of *Medical Care*. Her other professional activities include the Institute of Medicine, National Academy of Sciences; fellow, American Statistical Association; Population Association of America; and the National Economists Club. She is on the Board of Editors of the *Journal of Health Politics, Policy and Law*, and an editorial consultant to the *Journal of Public Health Policy*. She is also a member of the WHO Expert Advisory Panel in Health Statistics, and of the Harvard University Visiting Committee.

● **Bailus Walker, Jr.**, PhD, MPH, is Director of Public Health, Michigan Department of Public Health, and former Director for Occupational Health Standards of the Occupational Safety and Health Administration, US Department of Labor. Prior to that he was Director and Senior Scientist, Environmental Health Administration, Government of the District of Columbia, and served as Deputy Health Commissioner of Cleveland, Ohio, and Director of Environmental Health Services for Dayton, Ohio. Within APHA, he has been the recipient of the Browning Award for Disease Prevention (1979), and has served on the Governing Council, Awards Committee, Nominating Committee, Jails and Prisons Task Force, Committee on Biological Monitoring, Environment Section Council, and as APHA's representative to the Council on Education for Public Health which has responsibility for accrediting schools of public health and graduate programs in community and public health. His other professional affiliations include the National Environmental Health Association, Society of Occupational and Environmental Health, American Association for the Advancement of Science, American Society for Microbiology, USEPA Science Advisory Board, US Council on Radiation, and the US Toxic Substances Strategy Committee. Dr.

Walker received his undergraduate degree from Kentucky State University, his public health degree from the University of Michigan, and his doctorate from the University of Minnesota.

● **Gail Gordon**, BSN, DrPH, is Chairperson of the Department of Health Sciences, Jersey City State College. Her professional activities have included Health Policy Analyst, National Academy of Sciences/Institute of Medicine; consultant, New York State Consumer Protection Board, and New York State Commission on Health Education and Illness Prevention; instructor, University of Maryland School of Nursing; community health nurse, Montgomery County Health Department (Maryland); and Captain, Army Nurse Corps, Walter Reed Army Medical Center. Within APHA, she has been affiliated with the Medical Care Section since 1972, and has served on the Governing Council, various Section committees, the Program Planning Committee, and the Committee on Women's Rights. Her other professional activities include the New York City Public Health Association (Board Member and Co-chairperson, Public Policy Committee); Coalition for a National Health Service (Board of Directors); National Association for Public Health Policy (Chairperson, Medical Care Council); and Consumer Commission on the Accreditation of Health Services (Board of Directors).

The Governing Council also re-elected **George E. Hardy Jr.**, MD, MPH, for a two-year term as the Association treasurer; and elected three Vice Presidents representing the three major geographic regions of the Western Hemisphere. These are: **Herbert K. Abrams**, MD, MPH (*United States*); **Marie des Anges Loyer**, MPH (*Canada*); and **Roberto Belmar**, MD (*Latin America*).

Theodore J. Colombo, MPH, was elected Chairperson of the Executive Board.

In other actions, the Council adopted the theme, "Aging and Public Health: An International Perspective," for the 1982 Montreal meeting; and approved two amendments to the Association's By-Laws, one to permit publication of required information in any official publication of the Association, and the other to permit the use of data processing to accomplish the tallying of votes in Section elections. There were no amendments to the Constitution. The changes in the By-laws are given below:

Current Version**ARTICLE XIII Sections**

Section 2(b). Not less than ninety days prior to the annual meeting, the Committee on Nominations shall submit to the membership of the Section either by mail or by publication in an official Journal of the Association, the names of two or more members as nominees for the appropriate Section offices, the Section Council, and the Governing Council. There shall be at least two nominees for each position.

Amended Version**ARTICLE XIII Sections**

Section 2 (b). Not less than ninety days prior to the annual meeting, the Committee on Nominations shall submit to the membership of the Section either by mail or by publication in the official publication of the Association, the names of two or more members as nominees for the appropriate Section offices, the Section Council, and the Governing Council. There shall be at least two nominees for each position.

Current Version**ARTICLE XIII Sections**

Section 2(e). A Committee of Tellers shall be appointed by the Section Council to tally the written votes where a mail ballot is used and said Tellers shall report the results in writing to the Section at a business session during the annual meeting and to the Executive Director.

Amended Version**ARTICLE XIII Sections**

Section 2 (e). Where a mail ballot is used the ballots shall be tabulated and certified to the sections by a method designated by the Executive Board.

National Study Seeks Heart Attack Victims

The Hyperlipidemia-Atherosclerosis Study is a nationwide investigation into heart disease, the major cause of death in America today. Funded through a five-year grant from the National Institutes of Health, the study seeks to answer one of the major questions confronting the medical community: Will the reduction of cholesterol in victims of atherosclerosis, a disease ultimately leading to heart attack and stroke, be effective in retarding or regressing the disease process? The study utilizes a unique procedure which lowers cholesterol to unprecedented levels.

A study is currently underway which may prove to be the ultimate breakthrough in conquering America's #1 Killer, Atherosclerosis. Supported by the National Institutes of Health, the study is seeking participants from across the United States and Canada who

- are ages 29 through 64
- have suffered a first and only heart attack within the last five years,
- are not diabetic,
- have not had a stroke,
- have not had open heart surgery.

Potential participants are urged to contact the nearest center (see below) for information. The study works closely with participants' personal physician. Traveling expense is reimbursed and accommodations are provided.

Eastern Center—Philadelphia, PA 215/645-3340 Collect
Midwest Center—Minneapolis, MN 612/376-4494 Collect
Southern Center—Little Rock, AR 501/661-5291 Collect
Western Center—Los Angeles, CA 213/482-5011 Collect

NOMINATIONS INVITED FOR 1982 APHA AWARDS

The American Public Health Association is now seeking nominations for its 1982 awards, to be presented this year during the APHA 110th Annual Meeting in Montreal, November 14-18.

All nominations for these awards should be submitted on the prescribed forms which appear on pages 191-196 in this issue of the *Journal*, and must be accompanied with a current, complete curriculum vitae of the nominee.

To assist the selection committees in their deliberations, nominations are actively sought for consideration. By this mechanism, these awards become the true accolade of the public health profession—the recognition of fellow workers and their outstanding accomplishments in their fields of endeavor.

Sedgwick Memorial Medal

The APHA Awards Committee, chaired by Dr. Bernard Greenberg, will review the nominations for the Sedgwick Award and select this year's winner in April. The deadline for nominating individuals for the Sedgwick Award is March 25, 1982. Nominations should be sent to the APHA Awards Committee, APHA, 1015 15th Street, N.W., Washington, DC 20005. Nominations received after the deadline cannot be considered for the 1982 award.

The William Thompson Sedgwick Memorial Medal, established in 1929, is the oldest and highest honor presented by the Association. Awarded for distinguished service and the "advancement of public health knowledge and practice," the medal commemorates Professor Sedgwick who was president of APHA in 1915 and head of the Department of Biology and Public Health at the Massachusetts Institute of Technology from 1883 to 1931. He helped found the Harvard and MIT Schools of Public Health.

There is no restriction on the area of service to be honored. Contributions in the fields of research, administration, education, technical service, and all specialties of public health practice receive equal consideration. The award has been made annually since its inception, except for two years (1937 and 1945) when no award was given.

Sections, Affiliated Associations, Boards, and Committees of APHA are particularly encouraged to propose the name of an individual as a

candidate for the 1982 Sedgwick Memorial Medal. A separate form must be submitted for each nominee, and both sides of the form must be completed.

Jay S. Drotman Memorial Award

The Jay S. Drotman Memorial Award, established in 1979, gives recognition and impetus to the career of promising young public health professionals or students, 30 years of age or less, who have demonstrated potential in the health field (broadly defined) by challenging traditional public health policy or practice in a creative and positive manner. Neither academic credentials nor grades will be a factor in selecting the awardee.

The Drotman Award Judging Panel, comprised each year of the APHA President, Immediate Past Award Recipient, the APHA Executive Director, and an APHA member selected by the Executive Board, invites nominations that meet the above criteria. Nominations should be submitted by March 25, 1982 on the prescribed form published elsewhere in this *Journal*, and should describe the merits of the nominee. Send nominations to the Drotman Award Judging Panel at APHA headquarters in Washington, DC.

The winner of the award will receive \$350 cash, round-trip economy airfare to the APHA 110th Annual Meeting in Montreal, November 14-18, 1982, a commemorative plaque, complimentary registration for the Annual Meeting, and the opportunity to present a paper at the meeting if so desired.

This award is endowed by Dr. Peter Drotman in memory of his late brother, Jay S. Drotman, a 27-year-old health planning consultant who was killed in a mid-air collision of two airplanes in 1978.

Martha May Eliot Award

Nominations for the 1982 Martha May Eliot Award, recognizing achievements in maternal and child health, are now being accepted. Names of nominees and a statement of their achievements must be submitted to the APHA Washington office by March 15, 1982. The standard form, published in this issue of the *Journal*, should be used, and a copy of the nominee's

current curriculum vitae should accompany the nomination.

In nominating an individual, emphasis should be placed on the high quality and originality of his/her contributions, rather than on longevity in the field. Nominations are sought for persons who have made outstanding contributions to education, administration, or research in the field of maternal and child health. Along with honoring the individual winner, the award is presented for the purpose of bringing his/her achievements to the attention of related professionals and to the public; stimulating young people in the field to emulate the efforts resulting in such recognition; and adding to the stature of the field.

Nominees need not be members of the APHA.

There is no geographic limitation, but it is preferred that the nominees work in the United States, Canada, or Mexico, and that they still be active in the MCH field.

Established in 1964 under a grant from Ross Laboratories, the award commemorates the late Dr. Martha May Eliot, who was chief of the Children's Bureau before her retirement in 1956, a moving force in APHA's Section on Maternal and Child Health, and served as APHA President in 1958.

The award consists of a \$1,000 honorarium, a plaque bearing the likeness of Dr. Eliot, round trip coach airfare to the APHA Annual Meeting, and other incidental expenses. The Martha May Eliot Award Committee is chaired by Dr. Julius B. Richmond.

Epidemiology Course Announcement

The New England Epidemiology Institute announces a new course, entitled "Epidemiology—Methods and Applications," to be held March 3–5, 1982 at the Linden Hill Hotel in Bethesda, MD. Drs. Philip Cole and Kenneth Rothman will present modern concepts in epidemiology and their applications to the study of etiology, natural history of disease, and strategies in preventive medicine and public health. The course provides a synthesis of analytic techniques that have been developed during recent years, and illustrates the application of these techniques to research problems and disease prevention. Students will learn the criteria by which epidemiologic studies of various types are assessed.

This course, intended for professionals in health and related disciplines who wish to develop a familiarity with epidemiologic research principles, is especially appropriate for persons not actively engaged in epidemiologic research but who are required to evaluate and interpret such research. No previous study of epidemiology or biostatistics is required. Tuition is \$650. Registrants may receive Continuing Medical Education Credits (AMA Category 1) upon application. For more information, contact:

Dr. Nancy Dreyer
New England Epidemiology Institute
Dept. SC-15
P.O. Box 57
Chestnut Hill, MA 02167
617/734-9100

SEDGWICK MEMORIAL MEDAL

1982 NOMINATION

(Please print or type)

Full Name of Nominee and Degree(s) _____

Title and Organization _____

Address _____

Describe below in detail the current creative work, the distinguished achievements, or the distinguished service which make this nominee worthy of the 1982 Award indicated below. (Attach additional sheets as necessary)

a. Positions (titles and dates) held during performance of work for which nomination is suggested: _____

b. Publications relevant to particular achievements on which nomination is based: _____

c. Other honors and awards: _____



MARTHA MAY ELIOT AWARD

1982 NOMINATION

To Honor Exceptional Health Service to Mothers and Children

(Please Type)

Full Name of Nominee and Degree(s): _____

Title: _____

Address: _____

Describe below the nominee's unusual achievements in the field of Maternal and Child Health:

(Please include innovative aspects of achievements; the impact on other persons in the field; the influence on the development of services to meet health needs of mothers and children.)

(see reverse side)

I have completed the reverse side of this form: _____
(Signature of Nominator)

Name of Nominator: _____

Address: _____

Date: _____

Positions (titles and dates) held during performance of work for which nomination is made: _____

Publications relevant to particular achievements on which nomination is based: _____

Honors and Awards: _____

Return by March 15; Nominations received after this date cannot be guaranteed consideration for the 1982 award.

To:

***American Public Health Association
Martha May Eliot Award Committee
1015 - 15th Street, N.W.
Washington, D.C. 20005***

JAY S. DROTMAN MEMORIAL AWARD**1982 NOMINATION**

The Award was established to recognize a health worker or student, age thirty or less who demonstrates potential in the health field by challenging traditional public health policy or practice in a creative, and positive manner. Neither academic credentials nor grades will be a factor in selecting the awardee.

(Please type)

Nominee _____ **Birthdate** _____

Address (OFFICE) _____

(HOME) _____

Phone _____

Describe below in 250 words or less the merits of the individual being nominated as outlined above.

Nominator's Name: _____

Address: _____

Date: _____

Return to: American Public Health Association, Jay S. Drotman Memorial Award, 1015 15th Street, N.W., Washington, D.C. 20005. Nominations received after March 25, 1982 cannot be guaranteed consideration for the 1982 award.

Call for Abstracts: APHA 110th Annual Meeting

The American Public Health Association is now calling for abstracts for its 110th Annual Meeting, to be held November 14-18, 1982 in Montreal, Canada. The theme for the meeting is "Aging and Public Health: An International Perspective."

The Program Planning Committee, co-chaired by APHA President Stanley J. Matek and Executive Director William H. McBeath, and composed of representatives from APHA's Sections, met in early January at the Association's headquarters in Washington, DC to develop the Section-sponsored portions of the program, and to plan the theme-related Opening, Closing, and Special Sessions.

APHA's 24 Sections, as well as the four Special Primary Interest Groups (SPIGs) and eight caucuses, have begun their search for scientific papers of original research, not previously published or presented elsewhere, relating the theme to their own disciplines and areas of interest. Both theme-related and non-theme papers will be considered for inclusion in these sessions. Detailed information on the various types of papers and topics being sought appears in the January issue of *The Nation's Health*. A standard abstract form for use in submitting abstracts appears in this issue of the Journal, and in the January issue of *The Nation's Health*, along with names and addresses of Section representatives designated to receive abstracts for consideration.

The Executive Board recently adopted a policy that *contributed* papers presented at the APHA Annual Meetings can only be presented by a member of the Association. Non-members may author or co-author a *contributed* paper.

Authors are advised to limit submission of an abstract to only one Section, or to indicate on the abstract form the multiple Sections to which the same abstract is being submitted. When notified of acceptance of an abstract by one Section, authors should so advise all other Sections to whom they submitted that abstract, in order to prevent duplication in the program.

The *deadline* for submitting abstracts is *Friday, March 12, 1982*. Several APHA Sections require authors of selected abstracts to submit a three-page summary of their paper by April 15 from which final program presentations will be made; some APHA Sections require the three-page summary to be submitted with the abstract. Authors of papers accepted for presentation at the Annual Meeting will be notified in July. Abstracts may not be withdrawn after July 17, 1982.

All portions of the abstract form must be completed by the authors, including names and addresses of all authors, co-

authors, and presenters, so they can be indexed in the Annual Meeting Program and to receive mailings from the Association.

While Abstracts are *not* being sought for the Opening, Closing, and Special Sessions, suggested speakers for individual and/or panel presentations for these theme-related symposia may be sent to: APHA Annual Meeting Program Coordinator, 1015 15th Street, NW, Washington, DC 20005. Such suggestions will be referred to the appropriate planning groups from the membership of the Program Planning Committee. Participants in these General and Special Sessions will be invited by these planning groups.

Points to Consider when Preparing an Abstract

The APHA Section representatives listed on the back of the abstract form receive and review hundreds of abstracts for the Annual Meeting Program; only a small per cent of these are selected for presentation. A carefully done study may be overlooked if the abstract is poorly prepared. Abstracts should be *informative*, a succinct condensation of the findings of the study. The following points are intended to be helpful to persons planning to submit an abstract for this year's Annual Meeting:

- State the basic reason for doing the research, indicate the methodology used, briefly summarize the results, and present at least one implication derived;
- Statements such as "results will be presented" or "implications of this study will be considered" are not acceptable;
- Program descriptions are welcome if they contain *substantiating* or *evaluative* data;
- There should be new information and new ideas presented;
- Avoid elliptical or incomplete sentences; do not use abbreviations, acronyms, or terms that might confuse readers in disciplines other than your own.

Rules for Submission: Please follow the instructions on the abstract form. Unless authors follow these instructions, their abstract will not be reviewed and the authors will not be notified of the outcome of their submission. The volume of abstracts received necessitates this rule.

Montreal, Canada, Nov. 14-18, 1982

For directions on how to fill out abstract, see below

Date _____

***Authors, Affiliations, City, State (two letter abbrev.)

type abstract within box

type abstract within box

Is your paper suitable for a poster session? _____

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Editor's Note: The following is a list of the Section and Forum representatives to whom proposed abstracts for the annual meeting should be sent.

Community Health Planning

Anita L. Sanborn
Director
American Health Planning Association
1601 Connecticut Ave., NW
Suite 700
Washington, DC 20009

Dental Health

Alice M. Horowitz, MA
6307 Herkos Court
Bethesda, MD 20817

Environment

Roger L. DeRoos, PhD
Minnesota Dept. of Health
717 Delaware St., SE
Minneapolis, MN 55440

Epidemiology

Jess Kraus, MPH, PhD
UCLA School of Public Health
Center for the Health Sciences
Los Angeles, CA 90024

Food and Nutrition

Ellen B. Thompson, MS
Vermont Department of Health
Medical Services Division
P.O. Box 70
115 Colchester Avenue
Burlington, VT 05401

Gerontological Health

Saul Spivack, MS
Senior Research Associate
Rehabilitation Research and Training Center in Aging
University of Pennsylvania
2019 NEB Building
420 Service Drive, S-2
Philadelphia, PA 19104

Health Administration

Morris Schaefer, DPA
263 Rosenau Hall - 201 H
University of North Carolina
Chapel Hill, NC 27514

International Health

Ahmed A. Moen, DrPH, MHA
Assistant Professor
Office of International Health
Howard University
Annex 2, Room 116
515 W St., NW
Washington, DC 20059

Laboratory

C. Dwayne Morse, DrPH
Director
Division of Medical Laboratories
Minnesota Dept. of Health
717 Delaware St., SE
Minneapolis, MN 55420

Maternal and Child Health

Lorraine V. Klerman, DrPH
Florence Heller Graduate School
for Advanced Studies in Social Welfare
Brandeis University
Waltham, MA 02254

Medical Care

Nelda McCall
Director
Health Policy Research
SRI International
333 Ravenswood Ave.
Menlo Park, CA 94025

Mental Health

Ronald H. Nelson, PhD
Good Samaritan Mental Health Center
2222 Philadelphia Drive
Dayton, OH 45406

New Professionals

Arlene A. Granderson, MPH
Office of Health Resource Opportunity
3700 East-West Highway, Room 150
Hyattsville, MD 20752

Occupational Health and Safety

Barry S. Levy, MD, MPH
Dept. of Family and Community Medicine
University of Massachusetts Medical School
Worcester, MA 01605

Podiatric Health

Francine G. I. Schiraldi, DPM
520 West Avenue, 205
Norwalk, CT 06850

Population

Deborah Oakley
Research Area School of Nursing
University of Michigan
Ann Arbor, MI 48109

Public Health Education

Monica G. Reiss, MPH
100 Haven Avenue, Apt. 25B
New York, NY 10032

Public Health Nursing

Elizabeth Adams, RN, MPH
2586 Exeter Rd.
Cleveland, OH 44118

Radiological Health

Dennis Murphy, PhD
Battelle
P.O. Box 999
Richmond, WA 99352

School Health Education and Services

Laurna Rubinson, PhD
Assistant Professor of Health Education
University of Illinois
114 Huff Gymnasium
1206 South Fourth
Champaign, IL 61280

Social Work

Jean E. Daniels, DSW, MPH
Sociology Department
California State University, Northridge
Northridge, CA 91330

Statistics

Peter A. Lachenbruch
Department of Preventive Medicine
University of Iowa
Iowa City, IA 52242

Veterinary Public Health

Russell W. Currier, DVM
Chief
Division of Disease Prevention
Iowa State Department
Lucas State Office Building
Des Moines, IA 50319

Vision Care

Joan A. Polcar, OD
Illinois College of Optometry
3241 South Michigan Ave.
Chicago, IL 60616

Forum on Alcohol and Drug Problems

Lorraine Midanik, PhD
Alcohol Research Group
1816 Scenic Avenue
Berkeley, CA 94709

POLICY STATEMENTS*

Adopted by the

GOVERNING COUNCIL

of the

AMERICAN PUBLIC HEALTH ASSOCIATION

November 4, 1981

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* APHA Policy Statements are of two types: A **Resolution** is a concise statement of a specific action or series of actions endorsed by the Association. A **Position Paper** (PP) is defined as a major exposition of the Association's viewpoint on broad issues affecting the public's health.

8101: Hospice Care Standards, Education and Reimbursement

The American Public Health Association,

Recognizing that adaptation to cancer and other terminal illnesses in their latter stages requires:

- a) coping with the physical illness and its attendant problems such as pain and loss of functions, and
- b) coping psychologically, socially, and spiritually with life as it is affected by illness;¹ and

Recognizing that the caregivers often neglect the psychosocial dimensions of patient care; and

Believing that the hospice concept is a viable approach to providing optimal and humanistic care for the terminally ill and their families;² and

Acknowledging that while traditional medical care is directed toward cure or at least control of disease in individual patients, hospice care extends this health care concept and focuses on caring, not curing, with emphasis on the special needs of patients and their families who are coping with the latter stages of terminal illness; therefore

1. Encourages appropriate educational enrichment programs in hospice care concept for physicians, nurses, social workers, other health professionals, clergy and lay volunteers;

2. Supports the efforts of APHA-NLN, the National Hospice Organization, the Joint Commission on Accreditation of Hospitals,³ in collaboration with other professional organizations as appropriate, to establish optimum standards for hospice care in their appropriate settings;

3. Strongly urges the Health Care Financing Administration of the United States Department of Health and Human Services to include hospice care as a benefit under Medicare and Medicaid;

4. Strongly urges the health insurance industry to include hospice care as a benefit; and

5. Recommends that local and state health agencies take a leadership role in the appropriate planning for, development of and quality control assurance of hospice care programs.

References

1. National Cancer Institute, US Department of Health and Human Services: *Coping with Cancer — A Resource for the Health Professional*. Bethesda, MD: NCI/DHHS, 1980.
2. California, State of: *Report to the 1980 California Legislature on the Hospice Project*, Berkeley, California, 1980.
3. Falknor HP, Kugler D: JCAH Hospice Project Interim Report Phase I, 875 North Michigan Avenue, Chicago, Illinois 60611, July 1981, pp 12-13.

8102: Occupational Health and Safety Services for Minority Workers

The American Public Health Association,

Having consistently supported the right of every worker to a safe and healthy workplace; and

Having previously passed Resolution No. 6502 on the relationship of discrimination to the health plight of minorities; and

Noting that Black, Hispanic and Native American workers, representing a substantial proportion of the workforce, frequently are employed in the most dangerous jobs in an industry, often work in small establishments not covered by the Occupational Safety and Health Act, and have been neglected as epidemiological research populations; and

Recognizing that Black workers have a 37 per cent greater chance than Whites of suffering an occupational injury or illness,¹ are one and one-half times as likely as Whites to be severely disabled from on-the-job injury or job-related illness,² and face a 20 per cent great-

er chance than Whites of dying from occupational injuries or illness;³ therefore

1. Urges that clinical, legal, educational, and other occupational safety and health services be expanded with special emphasis placed on making services available to minority workers;

2. Recommends that occupational health and safety training, as an integral part of the curriculum of medical and public health schools, should place particular emphasis on education of minority health professionals and others who will serve minority communities;

3. Resolves that a safe and healthful workplace is a basic right, and believing that Equal Employment Opportunity Commission Title VII Guidelines would apply, encourages filing of complaints against employers for injuries and illnesses related to discriminatory employment practices;

4. Encourages epidemiological studies of minority populations to be conducted by government, universities, and independent research institutions to determine the relationship between occupational exposure and health effects among specific subgroups of workers, particularly pregnant women, given the particularly high risk for unfavorable pregnancy outcomes among minorities; and

5. Urges implementation of legislative provisions protecting workers, in this case minority workers, from discriminatory job loss when complaints about health and safety conditions are filed.

References

1. Kotelchuck D, *et al*: Occupational injuries and illness among Black workers. *Health Pac Bulletin* 1979;34:81-820.
2. Krute A, Burdette M: 1972 survey of disabled and non-disabled adults: chronic disease, injury and work disability. *Social Security Bulletin*, April 1978, p 11.
3. Kotelchuck D, *et al*: *op. cit.*, p 33.

8103: Use of Cost-Benefit Analysis in Public Health Regulation

The American Public Health Association,

Noting that the Reagan Administration is requiring cost-benefit analysis of public health regulations and has issued an executive order limiting action to regulations with a positive cost-benefit ratio;¹⁻³ and

Noting that most well-known economists responsible for the development of cost-benefit analysis oppose its use as a sole decision-making criterion;⁴ and

Understanding that cost-benefit analysis, while it may be appropriate as one of many tools for evaluating limited technical problems in public health, is subject to severe ethical and methodological limitations including:⁵⁻⁹

- the difficulty of placing a dollar value on life or well-being;
- that those likely to receive the greatest benefit from public health related regulations are unlikely to participate in the decisions about the values assigned, or the costs and benefits to be counted;
- that the costs of public health regulation often accrue to one group while the benefits accrue to another group, and no mechanisms exist for assuring adequate recompense for those bearing the health costs;
- that it is difficult to estimate the risk of disease and the effects of prevention;
- that analyses in the environmental and occupational health area often assess the cost per life saved but ignore other benefits such as reduced illness, improved function or increased property values;
- that the costs of compliance are difficult to calculate and, being based on current technology, ignore the possibility of cost-reducing innovation; and

Recognizing that cost-benefit analysis is being used to attack public health programs and regulation; and

Realizing that, as a nation, we would lose vital public health pro-

tection provided by regulations under the Occupational Safety and Health Act, the Mine Safety and Health Act, the Clean Air Act, and others, as a result of undue reliance on cost-benefit analysis, and that the loss of these protections will result in increased incidence of cancer, heart and lung disease, and other environmentally linked diseases,¹⁰ therefore

1. Encourages filing *amicus* briefs defending health regulation from inappropriate cost-benefit review; and
2. Recommends developing testimony on federal, state, and local legislation, sending letters of support to legislators and organizing grassroots letter writing campaigns to:
 - maintain and pass laws and regulations which protect health to the extent feasible, and
 - prohibit requirements that regulation must always demonstrate a positive benefit-cost ratio and forbid decision-making on health-related regulation solely on the basis of cost-benefit analysis.

References

1. Executive Order 12291, February 17, 1981. Washington, DC: The White House.
2. Deregulation: A Fast Start for the Reagan Strategy, *Business Week* March 9, 1981, p 64.
3. Werdenbaum M: How Much Regulation Is Too Much? *New York Times*, December 17, 1978.
4. Office of Technology Assessment, US Congress: The Implications of Cost-Effectiveness Assessment of Medical Technology, August 1980.
5. Subcommittee on Oversight and Investigation, Committee on Interstate and Foreign Commerce, US House of Representatives: Cost Benefit Analysis: Wonder Tool or Mirage? December 1980.
6. Office of Technology Assessment, US Congress, op.cit.
7. Kelman S: Cost Benefit Analysis - An Ethical Critique. *Regulation*, January/February 1981, pp 33-40.
8. Ashford NA: The Usefulness of Cost-Benefit Analysis in Decisions Concerning Health, Safety and the Environment. Presented at a Conference on Regulatory Controversy: The Case of Health and Safety, March 7-8, 1980.
9. Ibid.
10. Ibid.

8104: Opposition to Constitutional Amendments or Statutes to Prohibit Abortion

The American Public Health Association,

Recognizing that the US Congress is considering proposed Constitutional amendments and statutes that would prohibit abortion by modifying the US Supreme Court rulings of 1973 which declared the abortion decision in the early stages of pregnancy to be a private matter between the woman and her physician;^{1,2} and

Noting that these proposed amendments and statutes would not only make abortion under all circumstances a criminal act, with some providing an exception only to prevent the death of the woman, but also would grant full Constitutional rights to embryos and fetuses from the time of fertilization onwards;^{3,4} and

Recognizing that the Supreme Court ruling is consistent with APHA policy on abortion, including policy statement No. 7430, "Opposition to a Constitutional Amendment on Abortion"; and

Considering also the impact of such an action on the provision of health care, including the perilous legal climate that would be created for health professionals providing contraceptives and for those delivering medical care to pregnant women, particularly women experiencing obstetrical complications;⁵ and

Emphasizing both the health hazards to those women who would obtain unsafe illegal abortions in the event abortion laws became restrictive and the adverse social effects of coercing others to undergo unwanted childbirth; therefore

1. Urges the rejection of any proposed Constitutional amendment or statute which would have the effect of restricting the provision of safe and legal abortion services; and

2. Encourages all health organizations and health professionals to assess the health implications of these proposed Constitutional amendments and statutes and to inform the US Congress of their views.

References

1. *Doe et al vs Bolton*, Attorney General of Georgia, et al, Supreme Court of the United States, Opinion Number 70-40, January 22, 1973.
2. *Roe et al vs Wade*, Supreme Court of the United States, Opinion Number 78-18, January 22, 1973.
3. Garn et al: Joint Resolution, 96th Congress, First Session, Washington, DC, 1979.
4. Helms J: Joint Resolution, 96th Congress, First Session, Washington, DC, 1979.
5. Pilpel H: The fetus as a person: possible legal consequences of the Hogan-Helms amendment. *Family Planning Perspectives* 1974;6:6-7.

8105: Male Involvement in Family Planning

The American Public Health Association,

Recognizing that, "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so";¹ and

Recognizing that men have played an important role in contraception during this century, particularly prior to 1965 before use of the pill became widespread, and that their role continues today with the use of vasectomy, condoms, and withdrawal accounting for nearly 25 per cent of total contraceptive use among currently married contraceptive couples;^{2,3} and

Recognizing that few family planning services include men; one per cent of 3.6 million clients of family planning clinics in 1976 were men while there were seven million sexually active teenage men compared to four million teenage women;⁴ and

Recognizing that there is an increased interest among selected populations in the use of barrier methods of contraception^{5,6} which require partner cooperation for effective use; and

Recognizing that men's ability to become better informed regarding family planning, in order to prepare themselves to engage in informed decision-making, participate in use of a method, or support their partner in the use of a method, is limited by the current structure of services and reimbursement policies;⁷ and

Recognizing that men have shown a willingness to expand their parenting role by attendance at birth, engaging in infant and early child care, and responding favorably to pilot family planning and reproductive health care service projects, therefore

1. Seeks support for recognition of men's involvement in achieving fertility control and freely determining the number and spacing of their children by directly requesting the Federal Office of Family Planning to support male family planning services with at least 5 per cent of the federal family planning budget;

2. Recommends that public and private health providers take the initiative to generate interest in making the necessary information, education, and services available to men to enable them to better participate in birth planning through existing services and through support of new approaches;

3. Recommends third party reimbursement for male family planning services to providers of family planning and reproductive health information and services from Titles V, XIX, XX, and of major insurance companies;

4. Advocates the removal of sex discrimination from the provision of family planning and reproductive health services as a national policy for all public family planning programs; and

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5. Encourages the provision of male family planning services to adolescent males and the referral of sexually active male teenagers to family planning programs.

References

1. World Population Plan of Action, Bucharest, 1974.
2. Muller CE: Insurance coverage of abortion, contraception and sterilization. *Family Planning Perspectives* 1978;10:2, 71-79.
3. Ford K: Contraceptive use in the United States, 1973-1976. *Family Planning Perspectives* 1978;10:264-269.
4. Select Committee on Population, US House of Representatives, Washington, DC 1978.
5. Torres A: Organized family planning services in the United States, 1968-1976. *Family Planning Perspectives* 1978;10:83-88.
6. Coleman and Piotrow: Barrier methods series No. 5. *Population Reports*, September 1979.
7. US Bureau of the Census, Washington, DC, 1971.

8106: The Reagan Administration Budget

The American Public Health Association,

Recognizing that APHA has gone on record in support of increased funding for public health programs and a decrease in the military budget; and

Further recognizing that the Reagan Administration, while calling for reduced government spending, has actually increased the federal budget through excessive increases in military spending; and

Acknowledging that the severe cuts made in social and health programs by the Reagan Administration are contrary to APHA policy and will severely affect the health and well-being of middle- and low-income people, especially women and minorities; therefore

1. Calls for an immediate restoration of federal funding for health and social programs; and
2. Will establish and/or identify appropriate means by which to:
 - a) inform the membership about actions taken by APHA;
 - b) educate members regarding actions they should take as individuals; and
 - c) inform members about actions which should be taken with their other professional associations.
3. Will help to initiate regional, state, and local meetings to discuss strategy for mobilizing APHA membership to promote public health programs; and
4. Will join in coalition with other organizations (peace groups, senior citizens, labor, religious organizations, civil rights groups, and others) in pressing for this position.

8107: Dismantling of the Office of the Chief Dental Officer, USPHS

The American Public Health Association,

Acknowledging that dental disease is a serious health problem in the United States, as evidenced by the fact that 98 per cent of the US population has had the disease and about 30 per cent of the population under age 17 have never been to a dentist for treatment;¹ and

Recognizing that the Chief Dental Officer of the US Public Health Service plays a vital role in the Office of the Assistant Secretary for Health for developing, integrating, and coordinating dental policy on a national level; and

Recognizing that the US Department of Health and Human Services is planning to dramatically reduce the staff of the Office of the Chief Dental Officer and remove it from the Office of the Assistant Secretary for Health; therefore

Resolves to notify the appropriate individuals in the Administration, the US Department of Health and Human Services, Congress, and certain national health organizations, and encourage them to support the retention of the Chief Dental Officer in the Office of the Assistant Secretary of Health with an appropriate number of supporting staff for the Office of Chief Dental Officer so that it can continue to play a meaningful role in developing, integrating, and coordinating national dental policy.

References

1. Howie LJ, Drury TB: Current Estimates from the Health Interview Survey: US, 1977. Series 10, No. 126, USDHEW, PHS, National Center for Health Statistics, Hyattsville, MD, September 1978.

8108: Budgetary and Administrative Attacks on Occupational Safety and Health Regulation

The American Public Health Association,

Having consistently supported legislation, such as the 1970 Occupational Safety and Health Act and the 1977 Federal Mine Safety and Health Act, and having endorsed strong standard setting and enforcement of regulations; and

Having taken specific positions supporting a strong government program for the control of workplace hazards that cause cancer, calling for strict federal surveillance of state plans to ensure that they meet the criteria of being as effective as federal law, endorsing government regulations to limit noise exposures, criticizing policies that balance economic interest against long-term health effects, endorsing workers' right to know about occupational hazards and their own exposure records, and condemning discriminatory employment practices in relation to reproductive hazards; and

Believing that federal legislation and regulation have been effective contributions to protecting workers' safety and health;¹ and

Noting that the following current plans or proposals are contrary to all the previous APHA positions:

- Budget proposals will cut millions of dollars from the budgets of the Occupational Safety and Health Administration, the Mine Safety and Health Administration, and the National Institute for Occupational Safety and Health;
- Proposed regulatory review or withdrawal of standards covering lead, hearing conservation, cotton dust, labeling, cancer policy, and attempted withdrawal of the US Department of Labor from the Supreme Court cases on cotton dust and lead will provide less or delayed protection to workers and indicates the Reagan Administration's willingness to compromise public health in favor of economic interests;
- OSHA's decision to approve an ineffective state plan in Indiana sets a precedent for shifting responsibility for occupational safety and health to states that are ill-equipped to perform this function; and

Noting that budget cuts will cause 12,000 fewer federal inspections and 22,600 fewer state inspections of workplace hazards, the closing of several OSHA area offices,² and elimination of the NIOSH training program, including regional occupational health and safety education centers; therefore

1. Opposes Administration policies that will impede effective safety and health programs;
2. Opposes budgetary and other restrictions on regulatory implementation;
3. Joins with coalitions of unions, public interest groups, local committees for safety and health (COSH groups), professionals, and others interested in the health of workers to keep the public eye on occupational safety and health; and
4. Will transmit this resolution to the White House Regulatory Task Force, the Office of Management and Budget, the US Depart-

ment of Labor, including both the Occupational Safety and Health Administration and the Mine Safety and Health Administration, the US Department of Health and Human Services, the US Supreme Court, and appropriate Congressional committees.

References

1. US Department of Labor: Technical Analysis Paper No. 62, Compliance with Standards, Abatement of Violations, and Effectiveness of OSHA Safety Inspections Washington, DC, October 1980.
2. Coalition of Labor Union Women: Health and Safety Project Newsletter, March 1981.

8109: Canine Roundworms and Human Visceral Larva Migrans

The American Public Health Association,

Recognizing that human beings, especially children, become infected with the larvae of *Toxocara canis*, the common roundworm of dogs, when they ingest the infective eggs of the nematode in soil or other materials contaminated by dog feces; and

Noting that serologic studies indicate a prevalence of asymptomatic human toxocariasis varying from 1 to 10 per cent depending upon age, residence locality, and socioeconomic status of the population surveyed;¹ and

Noting that serious systemic disease (visceral larva migrans), visual loss, and even blindness²⁻⁴ may result from such infections in humans; and

Noting that dogs are present in 30 to 50 per cent of American households and that soil samples in parks, playgrounds, and other public places have been found highly contaminated with *T. canis* eggs;⁵ and

Recognizing that congenital transmission of toxocaral larvae from the bitch to canine offspring results in a very high prevalence of infection in young pups, and that nursing bitches also acquire patient infections at the time of whelping; and

Noting that safe and highly effective treatments exist for the elimination of the adult parasite from canines;⁶⁻⁸ therefore

1. Recommends that treatment and prevention of reinfection should be particularly directed at young pups and nursing bitches;
2. Recommends that further studies be encouraged to document the prevalence and morbidity associated with these infections in humans;
3. Further recommends that veterinary practitioners conduct appropriate client information programs with the goal of reducing the prevalence of the infection in pet dogs and minimizing the potential of transmission to human beings; and
4. Finally, recommends that local health authorities conduct widespread public information programs and support appropriate legislation to minimize the contamination of household environments and public places with canine feces.

References

1. Glickman LT, Schantz PM: Epidemiology and pathogenesis of zoonotic toxocariasis. *Epid Rev* 1981, (in press).
2. Zinkham WH: Visceral larva migrans. *Am J Dis Child* 1978;132:627-633.
3. Schantz PM, Glickman LT: Toxocaral visceral larva migrans. *N Engl J Med* 1978;298:436-439.
4. Pollard ZF, Jarrett WH, Hagler WS, et al: ELISA for diagnosis of ocular toxocariasis. *Ophthalmology* 1979;86:743-749.
5. Anon: Why do we let dogs foul our streets? *Br Med J* 1976;1:1486.
6. Schantz PM, Glickman LT: Canine and human toxocariasis: the public health problem and the veterinarian's role in prevention. *J Am Vet Med Assoc* 1979;175:1270-1273.

7. Herd R: Preventing visceral larva migrans. *J Am Vet Med Assoc* 1979;174:780-782.
8. Kornblatt A, Schantz PM: Veterinary and public health considerations in canine roundworm control: a survey of practicing veterinarians. *J Am Vet Med Assoc* 1980;177:1212-1215.

8110: Mandatory Beverage Container Deposit Legislation

The American Public Health Association,

Recognizing that legislation requiring mandatory deposits on soft drink and malt beverage containers is a means of reducing litter, conserving non-renewable natural resources, saving energy, reducing solid waste, and promoting a conservation ethic; and

Noting that the states of Oregon, Vermont, Connecticut, Iowa, Michigan, Maine, and Delaware have successfully enacted some form of beverage container deposit legislation; and

Affirming that experience in these states has shown that "deposit" laws are working;¹ and

Observing that "deposit" laws continue to be introduced in states without such legislation; therefore

1. Strongly supports the enactment of mandatory deposit legislation in states where such laws do not exist; and
2. Supports the enactment of national beverage container deposit legislation.

References

1. States' Experience with Beverage Container Deposit Laws Shows Positive Benefits. Report by the Comptroller General of the United States, Washington, DC: GAO, PAD 81-08, December 11, 1980.

8111: Disposal of Hazardous Wastes

The American Public Health Association,

Recognizing that the United States in 1980 produced an estimated 43 million metric tons of hazardous wastes and that this volume is projected to grow at 3.5 per cent per year;¹ and

Recognizing that the majority of these wastes are deposited in an estimated 30,000 landfill sites which all too often provide inadequate protection of water supplies or further public contamination from these wastes;² and

Recognizing that recent Environmental Protection Agency studies show that thousands of these sites need immediate remedial action to prevent direct public exposure to toxic chemical contents of these sites;³ and

Recognizing that most states which currently have such disposal sites are running out of space and the locating of new sites is very difficult due to public opposition;⁴ and

Recognizing that numerous studies have shown many existing drinking water supplies contaminated by man-made organic chemicals which will remain in such water for hundreds of years;⁵ and

Recognizing that the health implications of many of these direct and indirect chemical exposures resulting from the migration of hazardous materials are not known; and

Recognizing that much of the recently enacted hazardous waste regulations, such as the Toxic Substances Control Act, have focused on the safe handling, transport, and storage of hazardous wastes; and

Recognizing that inadequate attention has been given to reducing the volume of hazardous wastes or toward disposal other than through land burial; and

Recognizing that public support, especially in communities selected as appropriate sites for hazardous wastes treatment and disposal

facilities, will be essential for the successful implementation of national and state hazardous waste management strategies; and

Recognizing that the Association is in a unique position to contribute to the development of mechanisms which would stimulate the reduction of the volume of hazardous wastes and to explore options for disposal other than burial; therefore

1. Encourages the development and implementation of a mechanism to provide for economic incentives process innovation and modification, and for management strategies designed to reduce the volume of hazardous wastes being disposed of;

2. Supports the reallocation of federal monies from disposal on land to improvements in hazardous waste detoxification, treatment, containment, and disposal;

3. Supports the need for more health-related studies regarding the health effects of public and employee exposures to toxic chemicals now leaching out of hazardous waste landfills;

4. Supports the concept that the polluters be responsible for the cost of clean-up of hazardous waste; and

5. Supports the rights of the public, especially those directly affected by hazardous waste management and facility location decisions, to know how they may be affected, and to participate in a meaningful way in the development, evaluation, and selection of options, and in the ultimate decisions.

References

1. EPA Contract Report on hazardous waste disposal, Prepared by Booz, Allen & Hamilton, 1980.
2. Ibid.
3. Ibid.
4. EPA Concept Paper on Hazardous Waste Disposal, Federal Register, October 8, 1980.
5. DHS Report on Trichlormethane Contamination in Drinking Water Wells, Department of Health Services, Berkeley, California, 1980.

8112: Hazardous Waste Victim Compensation

The American Public Health Association,

Recognizing that the US Environmental Protection Agency (EPA) estimates that there are thousands of hazardous toxic dumps in the US; and

Recognizing that efforts to prevent exposures to toxic wastes have not been as successful as necessary; and

Recognizing that community residents in the vicinity of such dumps may suffer health problems from exposure to materials released in air, water, or dusts at these sites; and

Recognizing that the clean-up of toxic waste sites often exposes clean-up workers to highly hazardous levels of chemical and physical contaminants; and

Recognizing that under current "Superfund" legislation,¹ funds may be used for the costs of epidemiological studies, development of a registry of persons exposed to hazardous substances for long-term health effects studies and diagnostic services not otherwise available to determine whether persons in populations exposed to hazardous substances in connection with a release or suspected release are suffering from long-latency disease; and

Recognizing that the current law provides for the use of funds to finance "a program to protect the health and safety of employees involved in response to hazardous substance release"² administered jointly by the Environmental Protection Agency, the Occupational Safety and Health Administration, and the National Institute for Occupational Safety and Health; and

Further recognizing that the "Superfund" legislation does not provide for the compensation of victims of exposure to chemical wastes for out-of-pocket medical expenses or lost income,³ whether they be community residents, waste dump employees, or hazardous waste clean-up workers and investigators; and

Noting that the US Department of Labor has found⁴ that State Workers' Compensation Programs provide benefits to only a small percentage of victims of occupational exposure to hazardous substance; that such awards rarely cover the full costs of such diseases; and that due to the inadequacies of State compensation laws, victims are often forced to rely on Social Security and welfare programs; and

Recognizing that such businesses will have diminished incentives to reduce the hazards of such toxic wastes until full compensation costs are paid by chemical waste dumpers; therefore

1. Urges the Congress to adopt legislation which compensates both waste clean-up workers and community residents in full for medical care costs and lost income due to waste-related disease and to insist on strong implementation of the Toxic Substances Control Act in order to prevent worker and community exposure;

2. Urges that waste disposers' contributions to "Superfund" be altered to reflect costs of disease compensated;

3. Urges that all APHA Affiliates push for improvement in toxic-waste-related environmental/occupational disease compensation laws in their own areas; and

4. Joins in coalitions with professional, labor, environmental, consumer, and other organizations to promote this position.

References

1. Comprehensive Environmental Response, Compensation, and Liability Act of 1980 ("Superfund"), Section 111(c)(4). Washington, DC: US Congress.
2. Ibid, Section 111(c)(6).
3. Congressional Record, November 24, 1980, page S15002, statement of Senator Harrison Williams.
4. US Department of Labor: Interim Report to Congress on Occupational Disease, June 1980.

8113: Oil Spill Liability and Compensation

The American Public Health Association,

Noting that the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (Superfund), which was recently signed into law after much debate and compromise by Congress, is an example of much needed legislation which deals directly with the impact of hazardous chemicals on public health and the environment; and

Noting that the Act provides funds for the clean-up of hazardous substances released from inactive and abandoned hazardous waste sites and from industrial and transportation facilities; and

Noting that the Act places the liability for such releases on the owner or operator of a site at the time the hazardous waste was disposed of there and sets forth punitive damages on any party who fails to provide removal or remedial actions upon order of the President of the United States; and

Noting that although a large portion of the Hazardous Substance Response Trust Fund will be financed by taxes placed on crude oil, petroleum products are specifically excluded from the provisions of the Act; and

Realizing that major oil spills such as the wreck of the Argo Merchant near the Massachusetts coastline and the IXTOC oil well disaster in the Gulf of Mexico would not be covered by the Act and that other oil spills will occur; and

Recognizing that these spills severely damage our coastal environment and, in many cases, threaten the financial survival and well-being of fishermen and others who are dependent upon coastal economics; therefore

1. Urges that oil spill provisions must be included in Superfund legislation in order to effectively protect public health and our environment;

2. Will contact key Members of Congress, other government officials, and the public regarding the need for such legislation; and

3. Encourages its members to notify their Congresspersons of their support for this additional legislation.

8114: Strengthen and Maintain Agricultural Fumigation Standards for EDB (Ethylene Dibromide)

The American Public Health Association,

Noting that fumigation of farm produce is taking place in the State of California; and

Noting that EDB (ethylene dibromide) is a major chemical being used in that fumigation process; and

Noting that EDB has been shown to be carcinogenic through biological and animal testing; and

Noting that significant residues remain on farm produce from the EDB spraying, which may cause a significant public health problem in both the immediate and long-term periods; therefore

1. Calls upon the California Department of Food and Agriculture to retain the stricter California OSHA Emergency Temporary Standard;

2. Calls upon the Federal Occupational Safety and Health Administration to strengthen its federal EDB standard to be the same as the California Emergency Temporary Standard;

3. Urges letters be sent to the proper trade unions, federal and state OSHA agencies, and Congressional committees in support of the stricter California OSHA Emergency Temporary Standard for EDB.

8115: Emergency Temporary Standard for Worker Exposure to Ethylene Oxide

The American Public Health Association,

Noting that ethylene oxide (EtO) is a sterilant which is used extensively in hospitals and other institutional settings, is a major ingredient in automobile antifreeze, and is present in other industrial places; and that an estimated 100,000 people per year are exposed; and

Noting that recent studies have shown EtO to meet all criteria of a carcinogen: it is a bacterial mutagen; it has been shown to induce leukemia, mesothelioma, and mutagenic changes in rats; and human studies have shown increased mortality and increased cancer deaths due to stomach cancer and leukemia; and

Noting that because of this new information the National Institute for Occupational Safety and Health (NIOSH) amended its previous position and now recommends EtO be viewed as a potential carcinogen; and

Noting that the Occupational Safety and Health Administration (OSHA) recently refused to issue an Emergency Temporary Standard for EtO, and that this issue is currently in litigation; and

Noting the need for prompt action; therefore

1. Joins with groups now in litigation to require OSHA to issue an Emergency Temporary Standard for EtO which is in keeping with its carcinogenic risks; and

2. Urges communication with the US Department of Labor, involved labor unions, and Congressional Committees in charge of OSHA and occupational health oversight emphasizing the need for this Emergency Standard and the need to warn the exposed population.

8116: Civilian-Military Contingency Hospital System

The American Public Health Association,

Having learned that the US Department of Defense is requesting hospitals to participate in a Civilian-Military Contingency Hospital

System intended for care of an unprecedented number of serious casualties in a short period of time from an overseas war,¹ a situation which fits DOD's description of a limited nuclear war; and

Realizing that the expansion of hospital care capabilities for many thermal and blast injuries and the use of hospital staff time and energy for planning and testing such a system adds to the burdens of hospitals when their budgets are already badly strained particularly for services to those most in need; and

Believing that the participation of hospitals in planning and testing such a system implies approval of preparation for nuclear war and encourages acceptance in the health field and in the country generally of the concepts that nuclear war can be limited and that nuclear war is inevitable; and

Noting that the balance of available information indicates that nuclear war cannot be contained, it cannot be won and it cannot be survived by either side; therefore

1. Requests the US Department of Defense to terminate the Civilian-Military Contingency Hospital System; and

2. Urges all hospitals to refuse to participate in the Civilian-Military Contingency Hospital System.

References

1. CMCHS: In Combat, In the Community; Saving Lives Together. USDOD, 1981, Foreword page 1.

8117: Nuclear War and Nuclear Weapons

The American Public Health Association,

Noting the announcement on August 6, 1981, Hiroshima Day, to add the neutron bomb to our military nuclear arsenal, and the deployment in Western Europe of the Cruise and Pershing missiles; and

Believing that escalation in nuclear weapons development and production increases the potential for nuclear war; and

Knowing that there are already over 50,000 nuclear warheads in the world, of which 30,000 belong to the USA and that this represents an accumulated explosive power equal to 3 tons of TNT per person alive on earth, a quantity sufficient to destroy any country at least 20 times over; and

Recognizing that there is abundant evidence that it is not possible for nuclear war to be "limited" geographically, or to be won or survived; and

Acknowledging that protests have been registered in Europe against this deployment of nuclear weapons; therefore

1. Vigorously opposes the development and deployment of these nuclear weapons by the United States;

2. Strongly supports a multilateral thermonuclear arms freeze and strongly encourages the Government to initiate multilateral talks directed at limitation of nuclear armaments;

3. Notifies the United States President and Congress of this position; and

4. Notifies the public via the media of this position.

8118: Inter-Professional Cooperation in High Blood Pressure Control

The American Public Health Association,

Recognizing that barriers to cooperation begin in professionals' education in isolation from other disciplines, and that this separation is often later reinforced in daily interactions; and

Realizing that, where present, such barriers can constrict the flow of information, limit the application of knowledge and skills, and adversely affect the efficient delivery of high blood pressure control services; and

Noting that the absence of cooperative professional relationships contributes to inadequate control in more than two-thirds of 60 million Americans with elevated blood pressure;¹ and

Knowing that hypertension, one of the most chronic diseases in the United States today, is a contributing factor in the deaths of at least 800,000 Americans each year;²⁻⁴ and

Acknowledging that nonphysician health providers serve as a valuable resource in providing detection, education, referral, and follow-up services for patients with high blood pressure;⁵⁻⁶ and

Realizing that misunderstandings regarding levels of proficiency among professionals in the same discipline, as well as differences between professions in knowledge, preparation, and skills result in lost opportunities for services to high blood pressure patients; therefore

1. Encourages cooperation of all health care providers, professional societies, and schools in interdisciplinary hypertension programs which aid in the detection and control of high blood pressure; and

2. Calls attention to this proposed inter-professional cooperation by distributing this resolution to the appropriate professional societies, schools, and agencies.

References

1. The National High Blood Pressure Education Program, DHHS, Estimates based on definition of borderline and definite readings of 140/90mm Hg by the Health and Nutrition Examination Survey, National Center for Health Statistics, Washington, DC.
2. US Department of Health, Education, and Welfare: Blood Pressure of Persons 18-74 years, United States, 1971-72, Series 11, No. 150. National Health Survey, National Center for Health Statistics, Washington, DC, 1975.
3. Drew DE, Keeler E: Algorithms for Health Planners, Vol. 6, Hypertension, R-221516-HEW. Santa Monica, CA: Rand Corporation, August 1977.
4. Current estimate updated by the National High Blood Pressure Education Program, DHHS, 1981.
5. Ward GW: (editorial) The dental profession takes high blood pressure seriously. *J Prev Dent* 1980;6:163-165.
6. Levy RI, Ward GW: The optometrists and hypertension control — a cooperative effort is the key. *J American Optometric Association* 1979;50:529-530.

8119: White House Conference on Occupational Health and Safety

The American Public Health Association,

Having shown its commitment to the prevention of occupational death and disability by advocating major efforts at: 1) identifying environmental threats to workers and communities; 2) informing workers and communities of risks and the range of options available for preventing health decrement; 3) providing incentives to correct hazardous conditions; 4) promulgating and enforcing standards; 5) developing and expanding occupational health instruction in schools of medicine and public health; 6) developing and expanding occupational health services in state and local health departments; and 7) creating a national workers' compensation system, through resolutions, starting in 1949, recommending that federal, state, and local governments become actively involved in developing occupational health programs; and

Recognizing the continuing need for scientific studies of toxic effects of all chemicals and dusts, stronger federal and state regulatory and non-regulatory measures to safeguard the health and safety of workers, implementation of Congressionally mandated occupational health provisions of all Health Systems Agencies, and a national workers' disability compensation program that would provide the nation's workers with comprehensive services for treatment of job-related illnesses and injuries; and

Recognizing the need to review the actions of government agen-

cies, labor, and management in complying with Congressional mandates to prevent job-related death and disability as specified in the Federal Mine Safety and Health Act of 1977 and the Occupational Safety and Health Act of 1970; and

Noting that White House Conferences for several decades have provided the national leadership essential for seeking the successful resolution of numerous health problems; therefore

1. Urges the early convening of the long overdue White House Conference on Occupational Health and Safety; and

2. Urges that the conference consider the following important issues:

- a) elimination of job-related death and disability;
- b) initiation of a major preventive health campaign to protect all citizens; and
- c) effective containment of medical care costs.

8120: Vision Care Personnel Utilization

The American Public Health Association,

Noting that federal financial support for the education of various health professions is being cut; and

Noting that some medical specialties have been identified as having significant projected surpluses in the future;¹ and

Realizing that various vision health care professionals provide overlapping services,² which should be taken into account when allocating funds on a rational basis for health professions educational institutions and their students; and

Observing that the production of health personnel is influenced not only by direct federal funding but also by such indirect factors as barriers faced by nonphysician health professionals in federal and state health programs and research; and

Noting that increasingly scarce federal health personnel dollars would be best spent in projecting and producing health professionals who are to be utilized at their highest level of skills as determined by state licensure laws; therefore

1. Recommends that future legislation and regulations concerning funding of health professions education consider the impact of the utilization of all health providers at their highest level of skills, with minimum overlap, in determining health personnel needs;

2. Recommends that existing policies in federal and state health care programs and regulatory actions which prevent persons from selecting nonphysician health providers for covered health care services within their licensure, and thus inappropriately influence the production of physician specialists, be removed; and

3. Recommends that federal and state policies relating to funding of health care research be examined and adjusted so as to coincide with federal health personnel needs.

References

1. US Department of Health and Human Services: Report of the Graduate Medical Education National Advisory Committee to the Secretary, Volume 1. Washington, DC: US DHHS, 1980, p 4.
2. US Department of Health, Education, and Welfare: Supply of Optometrists in the United States: Current and Future. US DHEW Pub. No. (HRA) 79-18, Washington, DC: DHEW/H-RA, 1979.

8121: Employment of Expanded Function Dental Auxiliaries in Public Dental Care Programs

The American Public Health Association,

Recognizing that the health problems posed by dental diseases are

among the nation's greatest in terms of the number of people affected and the persistence of the diseases;¹ and

Recognizing that by age 17, almost 30 per cent of the US population under age 17 has never been to a dentist;² and

Recognizing that extensive research and experience show that employing Expanded Function Dental Auxiliaries (EFDAs) to perform those functions not requiring the training and experience of a dentist is one way of increasing the efficiency of the nation's dental care delivery system;³⁻⁹ and

Recognizing that the quality of EFDA restorative dental treatment has consistently been found to be at least equal to that of dentists, and that persons treated by EFDAs have reported high levels of satisfaction;¹⁰⁻¹² and

Recognizing that many local, state, and federal agencies are currently operating dental care delivery programs that provide dental care to populations who do not have access to dental care in the private sector; and

Recognizing that federal, state, and local public health dental programs are faced with dwindling resources, and could increase efficiency if able to employ EFDAs; and

Recognizing that many states have dental practice acts prohibiting the provision of services that would ordinarily be delegated to EFDAs;¹² and that federally operated dental programs are not bound by state dental practice acts;¹³ therefore

1. Resolves to encourage and urge all federal agencies that provide dental care or provide grants or contracts for the operation of dental care programs to employ and encourage the employment of EFDAs in such programs;

2. Encourages and urges all public program agencies at state and local levels providing dental care to populations which do not have access to dental care in the private sector to make maximum use of EFDAs whenever feasible; and

3. Encourages and urges a change in state dental practice acts so that public dental programs may utilize EFDAs in order to maintain and/or decrease the cost of providing dental services.

References

1. DHEW: Forward Plan for Health, 1978. Washington, DC: US Govt Printing Office.
2. Howie LJ, Drury TF: Current Estimates from the Health Interview Survey: US, 1977. Series 10, Number 126. USDHEW, PHS, National Center for Health Statistics, Hyattsville, MD, September 1978.
3. Abramowitz J, Berg LE: A four year study of the utilization of dental assistants with expanded functions. *J Am Dent Assn* 1973;87:396,623-625.
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7. Parker WA: Dental Therapy Assistant: Cost-performance Analysis - Final Report. Health Care Studies Division Report No. 76-006R. Fort Sam Houston Texas, US Army, Academy of Health Services, September 1976.
8. Robinson GE, Bradley EL: TEAM vs DAU: a study of clinical productivity. *Med Care* 1974;12:693-708.
9. Comptroller General: Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists and Taxpayers. HRD-80-51. Report to the Congress. Washington, DC: General Accounting Office, March 7, 1980.
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11. Lotzkar S, Johnson DW, Thompson MB: Experimental program in expanded functions for dental assistants: phase 3 experiment with dental teams. *J Am Dent Assn* 1971; 82:1067-1081.
12. Born DO: The Implications of Auxiliary Utilization for Cost-

Containment in Dentistry. Presented at the symposium, Implications for Future Cost-Containment in Dentistry, University of Minnesota, School of Dentistry, September 25-26, 1980.

13. Legal Provisions for Delegating Expanded Functions to Dental Hygienists and Dental Assistants. Chicago, IL: Division of Education Measurements Council on Dental Education, American Dental Association, 1981.

8122: Hospital Privileges and Postgraduate Training in Podiatry

The American Public Health Association,

Knowing that a shortage of podiatric residency programs currently exists (see Table 1); and

Knowing that almost all physicians serve a one-year or two-year residency after graduating from medical school;¹ and

Knowing that today's podiatry student acquires skills in addition to palliative care of superficial skin lesions, such as knowledge of drug prescription and medication, surgery on bones and soft tissues, use of X-rays, and other sophisticated techniques;² and

Realizing that podiatrists as members of the modern health care team have assumed an important role in the provision of foot care;² and

Believing that the podiatrist's responsibilities include being called upon as the primary care practitioner;³ and

Knowing that a maldistribution of podiatrists exists nationally, with greater numbers practicing in urban areas;² therefore

1. Encourages a greater awareness of the need for additional postgraduate training facilities for podiatric graduates;

2. Encourages health care institutions to expand their current structure by initiating podiatric residency programs for postgraduate training;

3. Requests that health care institutions review their bylaws and amend where necessary any portion which denies or inhibits trained podiatrists from gaining access to their diagnostic and operator facilities; and

4. Requests health care institutions to extend hospital privileges to qualified podiatrists for management of foot pathology.

TABLE 1 — Postgraduate Training for Podiatry Graduates

School	Year*	Graduates	Number of Residencies	Number of Per Cent
California College of Podiatric Medicine	1980	81	60	74
	1981	95	63	66
Illinois College of Podiatric Medicine	1980	148	69	46
	1981	152	82	54
New York College of Podiatric Medicine	1980	111	N/A	—
	1981	105	65	62
Ohio College of Podiatric Medicine	1980	133	86	65
	1981	139	N/A	—
Pennsylvania College of Podiatric Medicine	1980	105	66	63
	1981	107	78	73
TOTAL	1980	578		
	1981	598		

SOURCE: Unpublished data submitted from the five schools of podiatry via personal communication.

N/A: Not available.

* In 1980, 357 residencies were available to graduating seniors. Information was provided by the External Programs Office, Illinois College of Podiatric Medicine, Chicago.

References

1. US Department of Labor, Bureau of Labor Statistics: Occupational Outlook Handbook, 1980-81, p 377.
2. US Department of Health, Education, and Welfare, Public Health Service: A Report to the President and Congress on the Status of Health Professions Personnel in the United States, DHEW Pub. No. (HRA) 80-53, April 10, 1980, Washington, DC: US Govt Printing Office.
3. Levine P: A biopsychosocial model for primary care podiatry. J Amer Podiatry Association 1979;69:8.

8123: Death with Dignity

The American Public Health Association,

Recognizing that to the seriously ill and infirm, death is not only a distinct possibility, but sometimes preferable to any alternative; and

Believing that health care policy should emphasize the quality of life and dignity of death and assure self-determination and the right to refuse treatment and not blindly stress the continuation of life; and

Noting that a technologically-oriented health system frequently supports the futile prolongation of dying and ignores the emotional as well as physical needs of the terminally ill and their families;^{1,3} and

Believing that a national policy on long-term care would be grossly inadequate without recognizing the patient's right to die;³ therefore

Encourages states and the federal government to pass model "Right to Refuse Medical Treatment" legislation (similar bills have been passed in 12 states) which

- spells out a general right of the patient to refuse treatment of all kinds without the need for certification of a terminal condition;
- provides that this right be exercised in a document that takes legal effect after patient incompetency;
- provides for the naming of a person to help exercise this right after patient incompetency; and
- provides for legal immunity for following the patient's wishes, as well as civil and criminal penalties for ignoring them;^{4,5} and

Encourages the concepts of the "living will" and "ethics committees" in hospitals and other health facilities as examples of ways this policy may be implemented; and

Supports further study to better delineate the ethical, legal, and medical issues involved in the concept of the right to die.

References

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3. Bernard C: Good Life, Good Death: A Doctor's Case for Euthanasia and Suicide. New Jersey: Prentice Hall, Inc., 1980.
4. Society for the Right to Die: 1981 Handbook. New York: Society for the Right to Die, 1981.
5. Natural Death Act. California Statute, 1976, Chapter 1439, Health and Safety Code, *Section 7185 et seq.*

8124: Nuclear Accident Liability

The American Public Health Association,

Having previously recognized the relationship between national

energy policy and public health (resolutions No. 7845 and No. 7909); and

Noting that the Price-Anderson Act of 1957, as amended in 1966 and 1975,¹ limits the liability of the nuclear industry and the compensation available to the public in the event of a nuclear accident to \$560 million; and

Recognizing that the Act was enacted as temporary legislation necessary to boost the fledgling nuclear industry during its early development and was designed to expire in ten years; and

Noting that, more than 23 years later, the arbitrary limitation of \$560 million has not changed, in spite of a nearly 300 per cent increase in the Consumer Price Index² as well as an overall increase in the size of nuclear power plants and their proximity to dense population centers; and

Noting that the Atomic Energy Commission determined, as early as 1964, that a nuclear accident could cause 27,000 fatalities, 73,000 injuries, and \$17-280 billion in property damage, and that the arbitrary sum of \$560 million bears absolutely no relationship to the actual estimated damages of a nuclear accident;³ and

Recognizing that compensation for damages exceeding \$560 million is possible only through an act of Congress, a method of victim recovery that has rarely been effective; and

Considering that the federal government's willingness to bail out those who may be responsible for creating a nuclear disaster—as well as to guarantee loans for nuclear accident payments and serve as a direct indemnitor for a portion of the \$560 million—constitutes an unquantifiable economic and human risk subsidy of the nuclear industry; and

Considering that the Price-Anderson Act "holds harmless" anyone responsible for a nuclear accident, effectively excusing mistakes and careless operations throughout the industry, and creating a disincentive for safety in an already hazardous industry; and

Noting that no other industry is afforded such carte blanche protection against financial risks of operating, nor should such a subsidy be considered for other industries; and

Considering that the Price-Anderson Act forces the American public, and particularly those people who live or work near nuclear facilities, to assume the financial responsibility for a risk that the very companies profiting from nuclear technology refuse to accept or insure; and

Believing that requiring the nuclear industry to insure itself through traditional private sector sources will significantly add to the public accountability of the industry, and will act as a strong incentive for stringent safety precautions; therefore

1. Will actively seek the repeal of the Price-Anderson Act;
2. Strongly opposes any other limitation on the liability of the nuclear industry; and
3. Will support measures that will cause compensation for nuclear damages to be collected by the public from private insurance sources, industry insurance pools, and directly from the party (or parties) responsible for the accident.

References

1. Section 170 of the Atomic Energy Act of 1954 as amended, enacted in September 1957, Public Law 85-256.
2. Keiki Kehoe: Unavailable At Any Price: Nuclear Insurance, Environmental Policy Center, Washington, DC, 1980.
3. WASH-740, "Theoretical Possibilities and Consequences of Major Accidents in the Large Nuclear Power Plants," Update, Atomic Energy Commission, Washington, DC, 1964.

8125: Battered Women

The American Public Health Association,

Noting that violence against women is a serious public health problem of national scope and that each year 1.8 million American

women are victims of severe and repeated beatings in their own homes;¹ and

Noting that APHA previously recognized the problem of violence against women in resolution No. 8107; and

Acknowledging that domestic violence is very costly to society, producing an estimated loss of \$3-5 billion annually in abuse-related absenteeism and an additional \$100 million in abuse-related medical bills;¹ and

Seeing there are approximately 300 grassroots community-based shelters in the US which face severe funding cuts and frequently have waiting lists far in excess of available space (at Harriet Tubman shelter in Minneapolis there are seven times the number of requests for each available space); therefore

1. Supports the Domestic Abuse Protection and Services Bill introduced by Representative Barbara Mikulski (Maryland);

2. Endorses grassroots efforts to secure and retain funding from government and private agencies; and

3. Encourages public health agencies and hospitals to give special training to emergency room personnel in: advocacy for battered women; effective assessment and intervention techniques to assist women in battering situations; legal procedures; special needs of young women, elderly women, and women of color; building links with local shelters, and related community resources.

References

1. National Coalition Against Domestic Violence, Washington, DC, April 1981 fact sheet.

8126: Nestle Boycott

The American Public Health Association,

Recognizing that APHA has consistently supported international promotion of breastfeeding and that APHA endorses the WHO/UNICEF Code of Marketing of Breastmilk Substitutes as reflected in policy statements No. 7922 (Infant Feeding Advertising) and No. 7403 (Breastfeeding); and

Noting that the United States Government alone voted against the WHO/UNICEF Code of Marketing of Breast Milk Substitutes at the May 1981 World Health Assembly and noting that resolutions supporting the Code passed overwhelmingly in the US House of Representatives and the US Senate; and

Noting that every year an estimated 10 million infants in the developing world contract diseases¹ caused by inappropriate bottle feeding and an estimated 1 to 4 million of those infants die;² and

Realizing that over 10 years ago international health organizations identified increased promotion of infant formula as one of the major causes of decreased rates of breastfeeding and consequent infant disease in developing countries; and

Recognizing the nutritional, immunological, and psychological benefits of breastfeeding that make it the best infant feeding method for the first 4 to 6 months of life;³ and

Knowing that bottles and infant formula can rarely be safely used in conditions where poverty exists, and where mothers cannot read and do not have access to clean water, adequate fuel, refrigeration, and income;⁴ and

Knowing that the Swiss corporation, Nestle, S.A., has almost half of the infant formula market in the developing world;⁵ and

Reiterating the demands of the Nestle Boycott that: 1) Nestle end all promotion of infant formula through and to the health professions; 2) Nestle end the use of "mothercraft" or "milk nurses"; 3) Nestle end all direct advertising to consumers; and 4) Nestle end the giving of free samples of infant formula to new mothers; and

Agreeing that all women have the right to make informed choices about their method of infant feeding based on information prepared without commercial interest and on discussion with health care personnel who are free of commercial pressures; and

Recognizing that the APHA has decided not to use Stouffers' facilities for conventions; therefore

1. Endorses a boycott of all products and services of the Nestle Corporation and its subsidiaries; and
2. Encourages APHA members to join the Nestle Boycott and informs them how to do so.

References

1. Jelliffe DB, Jelliffe PJ: Human Milk in the Modern World, Oxford and New York: Oxford University Press, 1978, p 289.
2. Statement often made by James Grant, Director, UNICEF.
3. Lawrence RA: Breastfeeding: A Guide for the Medical Profession. St. Louis: Mosby, 1980.
4. Feeding Infants and Young Children: Report of WHO/UNICEF Meeting, Geneva, 1979.
5. Borgoltz P: Economic and business aspects of infant formula promotion: implications for health professionals. Advances in International Maternal and Child Health, 1982, Vol. 2.

Related Literature

1. Greiner T: The Promotion of Bottle Feeding by Multi-National Corporations: How Advertising and Health Professions Have Helped. International Nutrition Monographs, Series No. 2. Ithaca: Cornell University, 1975.
2. Wennen CAM: Decline of breastfeeding in Nigeria. Tropical Geographic Medicine 1969;2:93.
3. Nair S: Project to Monitor the Marketing and Promotional Activities of the Infant Food Industry in Selected Asian Countries. International Organization of Consumer Unions, Regional Office for Asia, Penang, Malaysia, 1980.

8127: Dietary Guidelines for Americans

The American Public Health Association,

Taking note of the growing evidence of the role of dietary factors in the causation of certain major chronic diseases;¹ and

Acknowledging that dietary modifications carried out over a sufficient time period offer promise of preventing and retarding the prospects of such diseases;² and

Recognizing that changing patterns of life-styles and eating require periodic changes in nutrition education and the content of advice given to Americans concerning their diets; and

Noting that the United States Department of Agriculture and the United States Department of Health and Human Services have jointly issued the Dietary Guidelines for Americans, on the basis of extensive research and review by these two departments;³ therefore

1. Endorses "Dietary Guidelines for Americans" as a basis for nutrition education and information for Americans;
2. Encourages use of the Guidelines by members of this Association when conducting nutrition education and counseling;
3. Commits itself to incorporating the Dietary Guidelines into future Association publications;
4. Urges the Secretaries of Agriculture and of Health and Human Services to continue active promotion of the Dietary Guidelines as listed in *Nutrition and Your Health*³ through:
 - publication of information and guidance materials concerning the Guidelines for use by the general public and by health professionals, including, but not limited to, *Nutrition and Your Health*;
 - wide distribution of the information and guidance materials described above; and
 - incorporation of the Guidelines, where appropriate, into the regulations governing the nation's federally assisted food and nutrition programs, and into guidance materials used for menu planning, food preparation, and nutrition education in these programs; and
5. Calls upon the Congress to encourage the activities described in No. 4.

References

1. Ahrens EH, *et al*: The evidence relating six dietary factors to the nation's health: consensus statements. *AJCN* 1979; 32, December.
2. DHEW: Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. DHEW(PHS) Pub. No. 79-55071, Washington, DC: US Govt Printing Office, 1979.
3. USDA and USDHEW: Nutrition and Your Health: Dietary Guidelines for Americans. Washington, DC: US Govt Printing Office, February 1980.

8128: Support for Federally Sponsored Food Assistance Programs

The American Public Health Association,

Recognizing that the federally sponsored food assistance programs, such as the National School Lunch Program, the School Breakfast Program, the Food Stamp Program, the Child Care Food Program, and the Summer Food Program, have been successful and effective in avoiding human suffering and meeting the nutritional needs of America's poor;¹⁻³ and

Recognizing that there is preliminary evidence that the Special Supplemental Food Program for Women, Infants and Children (WIC) has been shown to be successful in improving the nutritional and health status of infants and children in lower income families thereby impacting the future costs in dollars and human suffering from infant mortality and morbidity for those participants served; and

Acknowledging that the combination of high unemployment and inflation in food, housing, energy, and medical costs has increased the difficulty low-income families have in meeting their basic needs;⁴ and

Realizing that 26.5 million children participate in the National School Lunch Program; 3.8 million in the School Breakfast Program; 754,000 in the Child Care Food Program; 2.2 million women, infants, and children participate in the WIC program; and 22.5 million people participate in the Food Stamp Program;⁵ and

Noting that the FY 1982 Federal Budget makes major cuts in all of the federal food assistance programs (i.e., one-third of the child nutrition program budget and one-sixth of the Food Stamp Program budget);^{6,7} and

Noting that the budget cuts have little to do with either more effective program management, or the results of national nutrition surveillance or program evaluation research; and

Knowing that the budget cuts in these programs will have an enormous negative impact on the poor, both directly and indirectly; and

Understanding that many of the proposed budget cuts in the federal food assistance programs which were not accomplished for Fiscal Year 1982 will be attempted again for Fiscal Year 1983, along with new budget cuts, including proposals for nutrition block grants; and

Recognizing that without continuing federal support for the food assistance programs, it will be difficult to ensure that a national policy for meeting the nutritional needs of the poor will remain in place; and

Considering that the American Public Health Association is an advocate for the preservation and improvement of the health of the US public, and that the avoidance of hunger and promotion of proper nutrition is essential to the public health; therefore

1. Urges that Congress and the Administration continue the national commitment to optimum nutrition and health for all US citizens, especially those with low incomes, as expressed in the development and implementation of the federal food assistance programs over the last 40 years;
2. Urges these public officials and agencies to maintain and improve all of the federal food assistance programs as long as the need for these programs exists; and
3. Calls upon national and local officials, as well as all Association

members, to recognize and act upon solutions to the nutritional problems which will result from the budget cuts in the food assistance programs.

References

1. Kotelchuck M, *et al*: 1980 Massachusetts Special Supplemental Food Program for Women, Infants, and Children (WIC) Evaluation Project. Division of Family Health Services, Massachusetts Department of Public Health, Boston, 1980.
2. Nelson K, *et al*: The National Evaluation of School Nutrition Programs: Review of Research - Volume II. Santa Monica, CA: Systems Development Corporation, April 1981.
3. Kotz N: Hunger in America: The Federal Response. New York: The Field Foundation, 1979.
4. National Advisory Council on Economic Opportunity: Twelfth Report, Critical Choices for the 80's. Washington, DC, August 1980.
5. USDA, FNS: Management Information and Analysis Report. Friday Letter, April 1981, Washington, DC.
6. Jones JY: Reagan Administration Proposed Reduction in Funding for Child Nutrition Programs. Congressional Research Service, Washington, DC: The Library of Congress, March 1981.
7. Reagan Administration FY 82 Budget Proposal. Washington, DC: The White House, February and March 1981.

8129: Occupational Data on Death Certificates

The American Public Health Association,

Recognizing the continuing importance of occupation and industry as a factor in mortality; and

Noting that obtaining reliable data on occupations is a prerequisite to valid future studies; and

Realizing that the death certificate is still our single most important and most readily available record in public health statistics; therefore

1. Encourages the accurate recording on the death certificate of usual occupation/industry held by the decedent;
2. Encourages adoption of a standard occupation and industry classification system and standardized guidelines for coding occupation and industry on the death certificate to promote uniform data collection and data use;
3. Encourages continuing studies of the relationship between occupation/industry and mortality;
4. Encourages the awareness of those professional persons who are responsible for recording information on death certificates, in particular, the funeral directors, of the need for accurate and complete information on occupation and industry to be recorded on the death certificate; and
5. Recommends increased support from federal agencies, state health departments, foundations, and lay organizations to improve recording of occupation and industry data on death certificates.

8130: Support of Health Services Research

The American Public Health Association,

Recognizing that federal programs are a major source of health care, including preventive and rehabilitative services as well as diagnostic and therapeutic measures for large groups of the population. For example, the shift of many of these activities from federally administered categorical programs to block grants may have a major impact on those being served. It is essential, therefore, that information be available to assess the efficiency, efficacy, and effectiveness of health care programs in meeting the needs of the population. Without such information, it will become increasingly difficult, if

not impossible, to identify, for example, groups who are not receiving critical services, under- and over-utilization of services, and more appropriate ways of using available resources; and

Recognizing that federal support for the development and provision of health services is undergoing massive cuts; and

Recognizing that these reductions reflect significant shifts in the underlying philosophical, administrative, and fiscal bases for the delivery of health services; and

Noting that these shifts are accompanied by current budget proposals to eliminate entirely funding for the National Center for Health Care Technology, to reduce by 60 per cent in fiscal 1982 the funding for the National Center for Health Services Research, and significantly to impair the research capacity of the National Center for Health Statistics.* The curtailment of these and similar programs will seriously impair our capacity to: 1) identify affected populations; 2) document changes accompanying shifts in the allocation of resources and delivery of services; and 3) assess the safety, efficacy, ethical, and economic impact of new and emerging health care technologies; therefore

Opposes the disproportionate reduction in federal support for health services research and calls for the reinstitution of efforts both to assess the state of people's health and to understand the impact of changes in the delivery of services on the availability, equity, and effectiveness of health care.

8131(PP): Toward a National Policy on Long-Term Care for the Aging

I. Statement of the Problem

Introduction — The Demographic Imperative

Currently almost 25 million people, or over 11 per cent of the population in the United States, are 65 years of age and older. This population is projected to grow to nearly 32 million by the year 2000 and to 55 million—over two times the current number—by the year 2030. Within the elderly population, the group aged 85 years and over—the “old-old”—is projected to increase dramatically from its current 2 million to over 1.5 times that number by the year 2000. By the year 2030, this group will be nearly 2.5 times as numerous as it is today.

The “old-old” are most likely to require long-term care. They are at high risk for limitations in activity due to chronic conditions (six out of every 10 persons) and for stay in nursing homes (two out of every 10).¹ They may also face problems related to low income,² inadequate housing,³ high cost of health care,¹ etc. Because of the longer life expectancy of women, the problems of the elderly—especially the “old-old”—are increasingly those of women. Forty-one per cent of elderly women live alone in comparison to 15 per cent of elderly men.¹ In addition to the general problems faced by all aged, elderly women are more vulnerable to problems such as social isolation, depression, and institutionalization.

II. Purpose

The purpose of this position paper is to promote the development of a *comprehensive* national policy on long-term care for the elderly. The goal of this policy is to maximize independence and improve the quality of life. Issues concerning various aspects of a national long-term care policy have been addressed by the American Public Health Association (APHA)⁴⁻⁶ as well as by such major organiza-

*Reauthorization of these programs were enacted and budget authorization levels for fiscal 1982-1984 were established by the Omnibus Budget Reconciliation Act of 1981, i.e., Public Law 97-35. Severe reductions from these authorized levels are proposed in the Labor, Health and Education Appropriation Bills now being considered by the Appropriation Committees of the US Congress.

tions as Congress, the Federal Council on the Aging, the National Institute on Aging, the National Council on Aging, the Institute of Medicine, and the 1981 White House Conference on Aging.⁷⁻¹⁵ Although various dimensions have been included in suggested policy approaches, a comprehensive national policy on long-term care has yet to emerge. Such a policy must encompass the areas of employment, income, housing, transportation, medical care, mental health services, personal care, social services, nutrition, disease prevention, recreation, self-fulfillment, and death with dignity. In addition, a comprehensive national policy must broaden its scope to include the family. Support and reinforcement for those families who provide assistance for their functionally limited elderly, as in the British system, are essential policy components. A comprehensive policy is essential to this rapidly growing area to provide a consistent, national direction and to establish standards for setting priorities and allocating scarce resources.

The APHA is in a unique position to define and support the development of a comprehensive national policy on long-term care for the aging in light of: 1) its multi-disciplinary representation of health and medical professionals whose interests and skills are directly related to preserving and fostering the well-being of the total population; and 2) its identification with a wide variety of areas of interest which are related to the problems of the aging.

Defining the Area

There are numerous definitions of long-term care, focusing not only on services but also on population characteristics.¹⁶⁻²⁰ Although the wording differs among these definitions, the general agreement in underlying concepts yields the following “consensus” definition: long-term care refers to the range of medical, social, and personal care for persons with chronic physical or mental conditions who are functionally limited in that they require assistance in activities for daily living. The care, either continuous or intermittent, is required for an extended period of time, i.e., over the long-term, and can be provided either through a formal organization or by family and friends.

The Population

Because the prevalence of chronic conditions and their associated disability increases with age, the elderly—especially the “old-old” who are 85 years and over—are at greatest risk of requiring long-term care. Within the elderly population itself, use of health services was highest for those 85 years and over. In comparison to those 65-74 years of age, the “old-old” used hospitals nearly twice as often and nursing homes 14 times as often.¹ While most of the public funding and the concern with cost focus on the elderly receiving institutional long-term care, the majority of elderly persons (95 per cent) live in the community. Between 15-25 per cent have significant symptoms of mental illness. Almost half of the community-based elderly report some limitation of activity due to a chronic condition, ranging from a low of 41 per cent for persons ages 65-74 years to a high of 60 per cent for the “old-old”. For all elderly, from 1-4 per cent require assistance in either bathing, dressing, eating, or toileting. In contrast, 4 per cent of the “old-old” required assistance in eating, 7 per cent in toileting, 11 per cent in bathing, and 18 per cent in dressing.¹

Current Services and Funding

The increase in the demand for long-term care services has far outstripped the supply and has been associated with increases in costs. Expenditures for health services for people of all ages were 9 per cent of the Gross National Product. About 29 per cent of the expenditures supported services to the elderly although they comprise only 11 per cent of the population.²¹ Between 1960 and 1979, costs for nursing home care—the largest component of long-term care expenditures—rose from \$0.5 billion to \$17.8 billion,²² and are projected to rise to \$82 billion by 1990.²³ Currently, nearly 60 per cent of the cost for nursing home care—about \$10 billion—is paid by public monies. Medicaid accounts for 87 per cent of these public expenditures; Medicare for only 4 per cent. The expansion of Medicare

and Medicaid and their unexpected consequences for public finance have been extensively chronicled.²⁴⁻²⁶

The emphasis by Medicaid and Medicare on funding for institutional long-term care has led to an undersupply of non-institutional services and unnecessary institutionalization. In fiscal year 1979, for example, 41 per cent of Medicaid's expenditures (or about \$8.8 billion) went for nursing home care.²² In contrast, only 1 per cent went for home health and homemaker services. The Congressional Budget Office has estimated that only 20 to 40 per cent of the need for supportive living arrangements (i.e., personal care homes, congregate housing) is met; less than 20 per cent of the need for community-based services (i.e., home health care, adult day care) is met.¹⁶

Other sources of public funding include: Title XX of the Social Security Act (SSA); Title III of the Older Americans Act (OAA); various programs of the Veterans Administration; and the Supplemental Security Income (SSI) Program. Title XX of the SSA and Titles III and IV of the OAA support non-institutional services. Although SSI is basically a cash benefit program for the elderly, it is generally used by them to pay for care in domiciliary facilities and board and care homes. In 1975 these and other state and local programs accounted for only 16 per cent of the total public expenditures for long-term care; about one-third of these program expenditures went for non-institutional services.¹⁶

III. Objectives

A Framework for Action

The broad policy goal of maximizing independence of the elderly and improving the quality of life leads to a search for alternatives to institutional care provided in nursing and personal care homes. (Supportive living arrangements such as congregate housing and boarding homes do not fall within this definition of institutional care.) This emphasis on non-institutional care* reflects concern for the needs of the majority of the elderly—the 95 per cent living in the community—recognition of the vital role of the family in providing social and emotional support, and a general discontent over the last decade of public policies which have provided lopsided incentives for developing institutional services. It also reflects the need to control costs and to develop a range of long-term care services. Finally, it reflects a movement from the desire simply to provide one service for all functionally limited persons, regardless of their needs and preferences, to the intention of providing a continuum of services from which the person can select the most appropriate.

The need for long-term care is not determined solely by health and functional status. Rather, it is their interaction with other factors that determine the elderly's need for formal long-term care services. Hence, a comprehensive national policy on long-term care must be cognizant of the effects of such factors as: cultural and ethnic attitudes, informal support systems, environment, housing, safety, and nutrition.²⁹⁻³² Encouragement and assistance of the informal support system should receive special emphasis.

In working toward a comprehensive national policy on long-term care for the elderly that maximizes independence and improves the quality of life, goals and actions must address three critical areas: service delivery, coordination and planning, and education.

- **Service Delivery**—Service delivery includes all aspects of long-term care—locus (ambulatory and institutional), type (preventive, rehabilitative and maintenance), recipient (elderly and their families). It includes methods of regulation mechanisms for oversight by consumer advocates, as well as research into strategies for prevention, rehabilitation, and intervention. Because the family is a major source of assistance for the functionally limited elderly, long-term care also en-

compasses support to the caring family, not only in terms of respite services but also in terms of financial assistance.

A goal of a national policy on long-term care for the elderly is that federal financial support be directed to combining current services and supplementing them with additional services so as to offer the elderly consumer a continuum of care, including institutional and non-institutional alternatives. These newly combined services, directed toward maximizing independence, should be organized at local levels and should focus particular attention on the needs of patients transferred from mental institutions to nursing homes and on the special needs of minorities. Preventive services for the elderly are an essential part of long-term care.³³ They should include: health, social, and nutritional services; functional assessment; individual and group counseling; self-help groups; client education; immunization; and vision, hearing, dental, and foot care. In addition, research should be aimed at evaluating evolving services and identifying strategies to meet the diverse needs of the elderly in maximizing independence by maintaining current function, managing functional loss, and preventing (or delaying) further decline.

- **Coordination and Planning**—As with the delivery of health care in general, the provision of long-term care is characterized by gaps and overlaps in services and programs. Multiple public, private, and voluntary agencies share in the funding, direction, and provision of care. These agencies operate at local, state, and national levels and include service providers (such as city health and social service divisions), planning agencies (such as area agencies on aging and health systems agencies), and legislative and administrative bodies (such as the Senate Special Committee on Aging and the US Department of Health and Human Services' Health Care Financing Administration), as well as various consumer organizations. The coordination of health and social services which are scattered throughout the care system has been urged at all levels. Two crucial goals toward achieving service coordination are:
 1. Developing a single point of access to long-term care services at the community level for all functionally limited elderly. This single point of access should conduct a multi-dimensional needs assessment, develop a care plan, and coordinate the service received. For example, a case management system could be developed and supported at the community level whereby needs assessment, care planning, and service coordination would be offered;
 2. Supporting research and demonstrations to identify various models of a case management system and efficacious means to establish such a system, e.g., an umbrella agency which assesses the needs of the elderly and refers them to appropriate services.
- **Education**—Education in gerontology and geriatrics requires a four-part approach including: 1) an understanding of the psycho-social-cultural problems and issues of aging for all levels and types of providers who serve the aged; 2) specific training in geriatric specialties for a variety of health professionals and paraprofessionals and inclusion of elements of gerontology in the training for other specialties; 3) education of the elderly themselves with a focus on prevention and self-care; and 4) education of informal care givers with a focus on both care provision and coping with the stress it often creates.

Policy goals include: 1) identification of geriatrics and gerontology as fields needing special emphasis in educational curricula, training programs, and continuing education. The emphasis should include not only knowledge development and skills enhancement, but also fostering positive attitudes toward aging and the aged; 2) support for programs which give gerontological input to the existing training of health care providers; and 3) expansion of programs aimed at education for the elderly in such areas as service availability, entry, and payment mechanisms; self-care; preventive care; and nutrition. Ongoing evaluation should be part of such education with the goal of identifying the most effective programs and methods.

IV. Desired Actions and Recommendations

In addition to activities in these three critical areas, a framework

*This is not to deny that the need for institutionalization does exist and that quality institutional care is in some cases the best solution. Recent studies illustrate the negative aspects of the trend toward deinstitutionalization and, while they concentrate on the turning out of large numbers of people from mental health facilities, they also refer to the general institutional population.^{27,28}

for action toward developing a national policy on long-term care for the elderly must address the issues of service fragmentation, measurement of outcome, and incentive-based reimbursement. Activities in these areas include:

- *Precise delineation of responsibility among the multiple federal agencies involved in long-term care of the elderly*—While the mission of the National Institute on Aging (NIA) seems to lie clearly in the biomedical and psychological research area, there remains much confusion over just which agency is responsible for what. Several agencies are involved in supporting delivery of services, e.g., the Health Care Financing Administration, Administration on Aging (AOA), Health Services Administration, Social Security Administration (which includes the SSI Program, among others), and Veterans Administration (VA). Several agencies support training, e.g., AOA, VA, NIA, Health Resources Administration, and the National Institute of Mental Health (NIMH). Research is directed at various areas related to the health of the aged by at least all those agencies already noted together with many others, e.g., NIMH and the National Science Foundation. When other levels of government (state and local) are added, the confusion is further intensified. As a result, programs are duplicated at one extreme and important areas left uncovered at the other. A more clearly expressed set of mandates with better defined areas of responsibility and clear designation of lead agencies when more than one is involved represents a first step. Equally important, but perhaps more difficult to achieve, is the need for a coordination of programs at the local level. This may be best achieved by a pooling of fundings among different agencies working in an area—defined programmatically or geographically. At present a person needing long-term care may have to deal with a variety of agencies responsible for different aspects of such care. The problems of pulling together these disparate elements to form a comprehensive long-term care program are overwhelming. Such pooling of funds would also provide an opportunity to reassess the current priorities which so disproportionately favor institutions.
- *Research into the causes of mental and physical deterioration due to the aging process*—Such research can provide the basis for developing methods of prevention of such deterioration for future elderly populations. Special attention should be given to research on Alzheimer's disease and incontinence because they are the primary factors which precipitate nursing home stays.
- *Research to define the relative benefit of various care delivery modes for sub-groups with different levels of functional capabilities*—Currently lacking is a technology to measure outcomes with sufficient precision to make these comparisons. The ability to predict outcomes with reasonable accuracy would allow reimbursement to be tied to maximum functional status of patients rather than to services provided. With such a technology, a provider would be reimbursed based on the functional status of the patients, relative to their reasonable expectation of treatment outcomes. Demonstration projects which address this area must have solid evaluation designs incorporated into them at the outset so that their results can address fully the complex issues under investigation.
- *Funding for long-term care to create incentives for better care*—Neither the per diem nor cost-based payment systems provide such incentives. The overall goal of financing should be to maximize the quality of life in a cost-effective manner rather than merely extending the number of days of existence. Because the roles of housing and social supports have been shown to be critical elements in affecting the status of the functionally limited elderly, funding should encourage their development rather than simply enhancing the medical model with its emphasis on technology. To the fullest extent possible, reimbursement to achieve quality care should be based on outcomes, not on services provided. Further, reimbursement should emphasize self-help and incentives for informal providers; it should only focus on the public sector as a provider of "last resort."

V. The Method of Implementation

Each of the areas summarized above represents salient issues around which to develop detailed plans and organize action programs to achieve the desired goals. APHA will act as a catalyst in developing and operationalizing a comprehensive national policy on long-term care for the elderly as described in this paper by: 1) soliciting participation from groups with special interests in long-term care; 2) advising and assisting interested organizations in developing and implementing desired goals; and 3) urging constructive legislation and action.

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8132(PP): The Definition and Role of Public Health Nursing Practice in the Delivery of Health Care

I. Statement of the Problem

Significant changes in the health care delivery system and in professional nursing education and practice have affected public health nursing. As public health nursing has evolved, the definition has become obscured. To enable the specialty to maximize its contributions in the field of public health, it is necessary to analyze the essential elements and reclarify the focus of practice.

In the past, when public health nursing programs were fewer in number and similar in nature, the definition and role of the public health nurse were fairly clear. At that time, the definitions of public health and public health nursing were more or less synonymous with working in the community in official public health agencies which had a mandate to protect the health (physical, psychological, and environmental) of an entire jurisdiction, or working in traditional private and voluntary service agencies.

Health care professionals and the government focus considerable attention on the merits of primary health care, ambulatory care, and home health care, thereby reducing the incidence of institutional care.¹⁻³ Within an increasingly complex health care system, an extraordinary range of public, private, and proprietary health service agencies have emerged and continue to proliferate to meet these needs. Such rapid growth and diversification have challenged the preeminence of official and voluntary public health agencies. However, many of these primary and ambulatory programs for specific population groups have failed to grasp and deal effectively with the

opportunity to identify and promote improved health levels in significant risk groups under their care.

At a time when federal and state governments as well as consumers have placed an increased emphasis on the need to incorporate the concept of wellness (prevention of illness, promotion of health, and health maintenance), the potential of public health nursing has not been maximized.⁴⁻⁷ Reimbursement mechanisms and the growth of federal and state mandated categorical programs have encouraged a more narrow focus in service programs. Consequently, many health departments have either developed or expanded specifically focused services for particular illnesses rather than incorporating and promoting the principles of health promotion and disease prevention. Attempts have been made to increase public participation in the health care decision-making process. These changes demand greater preparation of those involved in educating the public in the decision-making process of health care. Further, the current situation of health care requires that its leaders be able to function effectively in the political arena to promote decisions supportive of the public's health.

The lack of overall systematic planning has resulted in considerable confusion. As new dimensions of nursing contributions to the system have emerged, there has been a lack of clarity concerning the focus of public health nursing as a field of practice and specific public health nursing roles. Trends in health care have caused a proliferation of personnel categories and brought many nurses without public health preparation into the community. This resulted in confusion within the health profession as a whole and society in general about what public health nursing is. There is further confusion within certain service agencies about what constitutes preparation for public health nursing practice.^{8,9} Consistent with the American Nurses' Association's "Conceptual Model of Community Health Nursing," the preparation of the public health nurse generalist should be at the baccalaureate level and the specialist at the graduate level.¹⁰

II. Purpose

The definition of public health nursing not only influences decisions about current public health nursing practice but also serves as a guide for the future. The APHA is concerned that the practice of public health nursing not be defined simply as nursing practice in a community-based setting; rather public health nursing needs to reflect a set of broad concepts that integrate both nursing and public health practice.

The purpose of this position paper is to: 1) establish a clear definition of public health nursing practice; and 2) clarify the role of the public health nurse within the delivery of health care. A clear definition will also serve two important additional purposes: 1) to educate health professionals, the public, and policy makers about the importance of public health nursing and the threats to public health caused by recent changes; and 2) to provide a focus to health professionals and policy makers for the effective utilization of public health nurses within changing systems of delivering and funding health services. To achieve this, the following definition and explanation of practice are offered:

Definition of Public Health Nursing

Public health nursing synthesizes the body of knowledge from the public health sciences and professional nursing theories for the purpose of improving the health of the entire community. This goal lies at the heart of primary prevention and health promotion and is the foundation for public health nursing practice. To accomplish this goal, public health nurses work with groups, families, and individuals as well as in multidisciplinary teams and programs. Identifying subgroups (aggregates) within the population which are at high risk of illness, disability, or premature death, and directing resources toward these groups, is the most effective approach for accomplishing the goal of PHN. Success in reducing the risks and in improving the health of the community depend on the involvement of consumers, especially groups experiencing health risks, and others in the community, in health planning, and in self-help activities.

Public Health Nursing Practice

Public health nursing engages community analyses in the *assessment* of the health needs to: 1) identify groups in the population—those families and individuals—at increased risk of illness, disability, or premature death; and 2) consider environmental as well as psychological, social, and personal health factors.

In *planning* for health care, public health nurses may actually be working with the family or individual, as well as the group, but the emphasis in planning is for the community as a whole and the inter-relationships between the individual, family, and community rather than for the individual. Consistent with this approach, a plan is developed that: 1) includes the full range of community and consumer involvement, especially from those groups at risk in health planning, in self-help, and in individual responsibility for personal health habits which promote health and a safe environment; 2) is consistent with community needs and expectations; 3) focuses on prevention at the most appropriate level; and 4) coordinates planning with other services and organizations in the community to maximize resources.

The *implementation* of the plan needs to be effective, efficient, and equitable. To accomplish this goal, public health nursing:

- provides nursing care that incorporates health promotion and disease prevention;
- works with groups, families, and individuals who have increased risk of illness, disability, or premature death;
- exhibits concern for those who do not present themselves for care through casefinding;
- functions in multi-disciplinary teams and programs;
- refers to other agencies in order to ensure comprehensive health and welfare services needed to support health care; and
- works with and through community leaders, health-related groups, and relevant social action programs to advocate and develop programs of health promotion and disease prevention.

The *evaluation* of public health nursing practice is based on: 1) the identification of measurable service program and patient care objectives; and 2) outcome criteria to determine changes, following intervention, in the health status of those groups to which programs have been directed.¹¹⁻¹²

III. Objectives

To maximize the contribution that public health nursing can make to the health of the community, this position paper recommends a definition of public health nursing which clarifies the essential elements and a description of the role for present and future use. Realistic adaptations need to be made in the scope of public health nursing according to the type of community-based health service in which public health nursing is carried out.

The Role of Public Health Nursing in the Health Care System

Public Health Nursing in Agencies with a Public Health Mandate—It is within those official and private agencies which have a mandate for protecting the health of the people, or providing comprehensive health care to a significant portion of the community, that the full scope of practice inherent in the definition of public health nursing can be most fully realized. Within such agencies, public health nursing, in collaboration with other disciplines, assesses the health needs of a total population group, sets priorities based on the high-risk status of certain groups, and then intervenes with health care services to those groups.

It needs to be recognized that constraints frequently exist which severely hamper nursing practice in these agencies which, historically or theoretically, have a mandate to serve the entire community. Integrated programming based on identified community needs has yielded to multiple federal or state funding requirements, and staffing has splintered along program lines. Staff may work in only one specialty area and report to a specific program director rather than to a community-based superior. This trend has resulted in a fragmenta-

tion of planning, and agencies have not explored the implications that their organizational structure and funding requirements have on their ability to work with targeted groups in order to improve the health of the entire community.

No public health nursing service within an agency having a public health mandate has the resources to meet all the identified health needs. After determining the needs that nursing and the health agency administration should meet, the nursing service in such an agency has an obligation to bring the unmet needs to the attention of community groups and individuals and to work cooperatively to ensure that efforts are made to meet them. A cooperative, inter/intra-disciplinary and agency team approach which includes the client will maximize the efforts of all to improve the health of populations. In working with others in the community, public health nursing is concerned with continuity of care and a system of "tracking" clients with identified needs to be sure that they are not lost in the social-health care maze.

Public Health Nursing in Agencies Serving a Specific Population—In most community-based health care agencies, the health of the entire community is not addressed. Agencies have become coordinators of categorical programs, so that only a narrowly defined segment of the community is addressed; but in rare instances are the total environmental factors of the neighborhood or community taken into account. Although the approach to the identified group may be comprehensive, some agencies focus their concern on the prevention of illness or nursing treatment for only one population group (such as infant care or home health). In others, the comprehensive care may be only for a specific health problem (such as hypertension or cancer). In still others, the program is only for a specific phase of a health problem (such as hospice or half-way house).

Perhaps the single factor that most distinguishes these programs serving a specific category of need from those with a broader public health mandate is the funding base used for planning and services. All too frequently, the "target population" or caseload consists of those individuals who meet program criteria for services for which there is reimbursement, and who appear for services. For the individuals who come in, comprehensive, holistic care with an appropriate emphasis on risk assessment, anticipatory guidance, etc., may be given; however, the planning, programming, and service generally do not include those who fail to come for care.

Consequently, the first step in the analysis of groups at risk is for the nurse to become familiar with the entire caseload or enrollment within the program. It is especially important to identify those families/individuals at the highest risk of more illness or poor recovery and for whom nursing resources can make a difference. The second step is to extend the scope of its services to those families and individuals within the community who meet the program criteria for service but who have not availed themselves of care or have dropped out of the program. This "out-reach" becomes critical when measuring the success of a program on improved health status of the entire community because the needs and achieved changes in a self-selected group seeking care may not accurately reflect continued health needs or health levels of the community as a whole.

The principal factors influencing the extent to which public health nursing practice is realized are: agency objectives and resources; the preparation of nursing staff, their competence and perceptions of their role; staff from other disciplines; and population expectations regarding health care.

Essential Elements for a Strong Public Health Nursing Service—Support elements essential to the maximum use of a public health nursing service are: 1) an operational commitment by organizational, civic, and legislative leadership to the principles of public health and to the contribution public health nursing can make to these health programs and to the health of the public; 2) a legislative mandate for inclusion of a public health nursing component in all local and state health departments and those voluntary health agencies which depend on tax supported reimbursement; 3) adequate funding to carry out the mandate of the agency; 4) supportive services and staff in an appropriate mix; 5) nursing leadership which is prepared in management and public health and committed to the principles and practice of public health nursing; and 6) organizational design in which the nursing administrator is in a position to effectively influence the decision-making process.

It is expected that clarification of the definition of public health nursing practice will provide a foundation for:

- defining expected outcomes of public health nursing care in terms of the health of target groups in the population;
- clarifying the responsibilities of public health nursing in the prevention of illness, promotion of health, and health maintenance;
- determining priorities for public health nursing services based on the identification of specific groups at risk;
- utilizing public health nurses appropriately as a result of the clarification of roles and responsibilities;
- clarifying the relationship of public health nursing not only to other nursing specialties and the community, but also to other health professions;
- facilitating the development of statements about competencies;
- providing guidelines for use in professional nursing educational programs to compare objectives and content to the essential elements identified for the practice of public health nursing; and
- clarifying career pathways and career mobility options in public health nursing.

IV. Specific Actions Desired by APHA

- A. APHA endorsement of the definition and role of public health nursing and of the recommendations for organization of health care to increase the utilization and effectiveness of public health nurses as contained in the position paper; and
- B. Dissemination of the position paper to specific organizations and agencies.

V. Methods for Implementation

Written reference and verbal communication which lends support for the definition and role of public health nursing by supporting program planning and development consistent with concepts in the position paper.

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Medical Care Call for Abstracts

The Medical Care Section of the American Public Health Association is calling for abstracts of research dealing with the organization, financing, and utilization of health care. These abstracts must describe projects which will be completed by June 1982. The papers selected will be presented at the 110th Annual Meeting to be held November 15-18, 1982, in Montreal, Canada.

Abstracts must use the standard form appearing in the January and February 1982 issue of *The Nation's Health* or available from the contact below. All submissions to the Medical Care Section must be postmarked no later than March 12, 1982. Please submit to: Nelda McCall, Director, Health Policy Research, SRI International, 333 Ravenswood Avenue, Menlo Park, CA 94025.